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THE MEDICAL ANALECTIC AND EPITOME

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

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R. W. AMIDON, M.D.

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EDITED BY R. W. AMIDON, M.D.

VOL. VII., No. 1. January, 1890. WHOLE No. 153.

LEADING ARTICLE.

Peabody (G. L.) on the Therapeutics of Typhoid Fever. — The results in the treatment of typhoid fever continue to be so bad in general in this country as to constitute a chronic opprobrium to the art of medicine here. We do not seem to be capable of approaching, at least in New York, the low rate of mortality which has rewarded the efforts of the medical profession in many of the cities of Europe. While we endeavor to explain our relatively higher death-rate by various differences which, without doubt, exist in the matter of collating and recording statistics in different countries, and while we may have to deal with a larger percentage of *bad cases*, cases which come under treatment in the hospitals late in the disease—too late, indeed, to allow of any thing like active therapeutic procedures —still, after making every allowance for local differences of these descriptions, it must be admitted that our death-rate in this disease is far higher than it should be. I believe, too, that the fact that we have not as yet arrived at any thing at all resembling a general consensus of opinion regarding its treatment is in itself evidence that many cases must be improperly treated, and that in this way much of our high mortality is to be accounted for.

Those who still adhere to the expectant plan of treatment are still in the large majority here. The expectant plan seems in a general way to make us quite content with our bad results, and to lead us to expect the patient to die if he becomes gravely ill. In this plan of treatment practically nothing is done unless symptoms in themselves very disturbing or grave, or even threatening, develop; and then much is often done that is likely to be pernicious in its effects. Doctors of this class seem to be pretty well in accord as to the proper plan of procedure, and to believe that a simple *symptomatic treatment* is the rational one. If a patient have a headache he receives the bromides, or an ice cap, or both, depending upon its severity; if he develop a bronchitis he is given opium, or cough mixtures, or inhalations; if he suffer from tympanites he is given turpentine, or turpentine stupes are applied; if he have a diarrhœa he is given opium and astringents; if hemorrhage from the bowel occur, to the opium is added tannic acid or gallic acid, or some other equally useless and disturbing drug; if he become delirious, the dose of the opium is increased, or he is physically restrained; and, most pernicious of all, if his temperature reach what is considered a dangerous height, an elevation which, long continued, would become incompatible with life, he is given a *large dose* of some antipyretic drug, and his temperature is suddenly reduced to a level which may be several degrees below the normal. Often this objectionable procedure is repeated in an almost rhythmical way for several days or weeks; and if, accompanying the fall of temperature thus produced there be a degree of prostration and feebleness of the heart which is alarming in itself, then, to counteract this bad symptom for which the drug and the doctor are responsible, alcoholic and other stimulants are given in large amount. This method of treatment—if it be proper to call that a *method* which seems to lack all true system—is often dignified by its advocates by the appellation *rational*. In fact, however, it would

be difficult to devise a more irrational method than the symptomatic method, carried to its logical issue. It would be quite as proper to treat perityphlitis symptomatically as to treat typhoid fever so; and yet who would think of treating the constipation of perityphlitis by purgatives? Who would now think of withholding food or drink of proper kinds from a fever patient merely because he may prefer, having no appetite, to be left undisturbed rather than to take an adequate supply of nourishment at definite intervals? And yet, if we are to be guided simply by *symptoms* in the treatment of this disease, the presence of anorexia should lead us sometimes greatly to diminish, and sometimes totally to withhold, the supply of food.

Unfortunately, those of us, on the other hand, who believe in treating the disease upon some other and more definite system, are still very far from being in accord as to the best method to pursue in the average case.

In the uncertainty which still prevails in this branch of therapeutics, it would seem that any one possessed of any facts bearing upon the subject need offer no apology for presenting them to his brethren.

During the past year it has fallen to my lot to treat about fifty of these patients, chiefly in the New York Hospital and the Bellevue Hospital. It would be premature to say that results were due to treatment, inasmuch as this number of cases is very small, and also because the same method of treatment was not pursued in each case; but that the results followed the treatment, and that, all things considered, the results have been in the main satisfactory, seem to justify a brief publication of the general plans adopted.

That the severity of the type of fever prevailing in one year may differ greatly from the severity of the type of the next year, has often been noted. As the fever prevailed here last year it seemed to me to be of much less severe type than is usual in New York; and this year it seems to me to be fully up to the average degree of severity. It may, therefore, well be that good results, which in numerous cases attended the plan of treatment by intestinal antisepsis last year, are really to be explained by the fact that the disease which prevailed at that time was of an unusually mild type. The antiseptics which I used last year in the New York Hospital were *resorcin* and *beta-naphthol*. When patients entered the hospital sufficiently early in the disease, that is to say, within the first ten days, the routine method was to administer a calomel purge of ten grains, and then immediately to follow this drug by a dose of one of these antiseptics, which was repeated at varying intervals, day and night, as a rule, until the temperature became normal, and remained so.

When resorcin was used, it was given in the dose of five grains every four hours; when beta-naphthol was used, its dose was two grains, given every two, three, or four hours, depending upon its effects. These drugs were administered in pill form, and each pill was carefully coated with keratine, to insure it against changes to which it might have been subjected in the stomach. Thirty-three well-marked cases of this disease came under my care in this hospital last year, and of these, twenty-seven were treated antiseptically in one of the ways indicated.

But little use was made of any of the newer antipyretic drugs, though in some cases occasional doses of phenacetine were administered. This formed no part of the *plan of treatment*, and was ordinarily given only a few times when the temperature remained persistently high.

The effects of the antiseptics upon Ehrlich's reaction were interesting. This reaction, even though it might have been ever so plainly present when the patients began treatment (and it was so almost invariably), usually disappeared after the first few doses, and remained constantly absent while the drugs were given. In several cases, for experimental purposes, the drugs were stopped and the reaction promptly returned, to disappear again when the administration of the drugs was resumed. Of unpleasant consequences of these drugs, I have to record the occurrence of blood, albumen, and casts, in the urine in a few patients who took beta-naphthol. These symptoms were always looked upon as positive indications to discontinue the drug, and they disappeared promptly when it was stopped. Resorcin produced absolutely no unpleasant effects.

The effects upon the temperature and duration of the disease seemed sometimes quite unmistakable, and to be about the same in the cases of those who were taking either drug. In six cases the fever lasted

seventeen days or less, in three it lasted only two weeks, and in nine cases the fever ceased entirely in just three weeks—all from the date of its commencement. In the other cases it lasted generally about four weeks, though in a few instances it continued over four weeks and did not seem to be materially influenced by the treatment. In two of these it lasted five and six weeks respectively. Among this latter class, however, are included two cases which can hardly be said to have been subjected to this plan of treatment, for they died in one and two days respectively after the treatment was begun.

Of these twenty-seven patients five died; but of these one was under this treatment only one day, two others only two days, and a fourth only six days. Of these deaths, one was due to extensive ulceration of the colon with profuse and wasting diarrhœa; one to profuse hemorrhage; one to lobar pneumonia; and two to parenchymatous nephritis. These two latter were treated by beta-naphthol and resorcin, respectively one and six days. In consequence of its short duration the treatment could hardly be considered the cause of this grave symptom. The height of the fever seemed to be even more markedly affected than its duration, and the comfort of the patients was proportionately promoted. In most cases it did not rise above 103° F. after treatment was begun, and it ranged usually between 100° and 102°.

Twenty-two of these patients were males, and five were females. All but seven were twenty-one years of age or older, and these seven were aged respectively eight, eleven, fourteen, sixteen, seventeen, eighteen, and nineteen years. The fatal cases were aged respectively seventeen, twenty-four, twenty-five, twenty-six, and thirty-five.

Milk was always the chief and, usually, the only food, until the patients became *very hungry* shortly before the temperature became normal, at which time eggs, chops, or steak were allowed.

Excepting the complications mentioned in relation to those who died, but very few and chiefly insignificant complications occurred. There were but two relapses, and these were not serious.

Diarrhœa was present among the early symptoms in a majority of these patients, and it was usually well influenced by the drugs given without opium or other astringents.

The eruption was nearly always present, and was not affected by treatment.

Albuminuria was often present, but never became an alarming symptom, except in the cases of the two patients who died of nephritis after having been under treatment one and six days respectively.

Estimated by mortality percentage alone, this record cannot be claimed as a brilliant showing for intestinal antisepsis; and it may well be that further experience will lead us to abandon the hope of being able to attack this disease at the site of its most marked lesion; but, all things considered, the results are certainly better than those which have followed the expectant plan of treatment in any year in this hospital.

It would be a source of great regret to me to give the impression that I consider this method of treatment as to be compared with the antipyretic effect of cold water applied to the surface of the body.

Unfortunately, however, two factors of vital importance in the treatment by cold baths seem likely always to be lacking here. The absence of these will probably always prevent our being able to save as large a proportion of patients ill with this disease as is now saved in Germany, and must reconcile us to our higher mortality, although I firmly believe that our death-rate, even under existing unfavorable conditions, is needlessly high. I allude primarily to the fact, to which reference has already been made, that patients habitually come under observation and treatment later in the disease than is the case in Germany. It is well known that in Germany and Austria many patients are received into hospitals with various trifling maladies that would not be supposed to justify them in seeking hospital treatment here. Thus people acquire the habit of going to hospital upon comparatively slight provocation in general, and do not wait, as is so commonly the case here, until their illnesses become pronounced and severe. It is, I think, exceptional for us to see in a hospital a patient in the prodromal stage of a typhoid fever, or even in the first few days of the pyretic period, except when we give him the disease in the hospital, as sometimes happens. This coming under treatment late deprives them of *some* chances of recovery, no matter what plan of treatment be adopted. The second misfortune which militates against our success in the treatment of this grave disease, is the un-

satisfactory manner in which our hospitals are conducted. The shifting attendance of several doctors, each for a few months only in every year; the rapid changes by rotation in the house staff; the constant changes in the nursing force, and often the unsatisfactory character of the nursing;—all these evils render it impossible for most physicians to carry out promptly, efficiently, and with due regard to the exigencies of each case, and on a large scale, any such thorough and systematic method as the cold-water treatment of fevers. We cannot ourselves become thoroughly familiar with the method, and cannot, of course, properly train and discipline a shifting and temporary body of assistants and nurses.

In the face of these discouraging facts, I have lately been trying to accomplish the principle of Brandt to a certain extent by other means than the cold bath. We receive into Bellevue Hospital a considerable number of patients suffering from this disease. But they are recruited largely from the poorly fed, badly nourished, and intemperate classes, and they usually come under treatment late in the disease. Many of these patients do not bear the cold full-bath well. The depression which it causes seems to be too profound, and the reaction from it very slow.

Accordingly, I have been trying to keep the temperature of the patient constantly at or below 102° F. without the use of cold baths. This is often well accomplished by the *cold-pack*, administered whenever the temperature rises above 102°, no matter how frequently it may need be applied. Few even of this unpromising material do not bear this procedure well, and only occasionally is one encountered in whom the pack when properly applied is not capable of causing a prompt reduction of temperature. Occasionally a patient is met with whose temperature shows such a tendency to rise immediately after the pack as to render the repetition of the procedure necessary after but a brief interval. Under these circumstances I have found it desirable to combine the wet pack with the administration of a small dose of an antipyretic.

It is never desirable in this disease to give these drugs in the large doses which were in vogue when we first began to use them. Moreover, it is well to bear in mind that they are rapidly eliminated from the body, and that to be of continuing effect they must be given in small doses. No good is likely to result from an occasional large dose of them.

If, however, we use them *in small and frequent doses to supplement the effects of the cold pack*, I believe that they become of distinct value in the treatment of this disease.

Many patients whose fever is not controllable by cold-packs alone respond promptly to a cold-pack *plus* five grains of antipyrin, the latter given as often as *every hour*. Both these should indeed be repeated as often as this while the temperature continues above 102°.

It soon ceases to be necessary to repeat either at very short intervals, and after a few days the drug can usually be discontinued entirely and the frequency of the cold-pack greatly diminished. The latter is rarely necessary oftener than four or five times in twenty-four hours.

Once in a while it happens that the packs are not well borne at the commencement, and the fall of temperature caused by them may be then not sufficient to justify their continuance.

In such cases I have found that a few doses of an antipyretic drug, just enough to cause the temperature to fall a few degrees, can be well followed by the combination of the packs and antipyrin, as already described.

This endeavor to carry out the principle of Brandt, in so far as it relates to keeping the temperature continuously low throughout the disease, is certainly worth a trial, and can be recommended to those whose clinical material and resources do not allow of the use of the cold full-bath. This is probably the most important principle involved in the antipyretic treatment of fevers, and experience has led me to believe that it will commend itself to all who apply it consistently *in any way* to a considerable number of cases. I have treated a few cases throughout their period of fever by the administration of five grains of antipyrin every hour, and a few others by giving small doses of sulphate of thallin every hour in the same way as long as the temperature remained above 102°. The elimination of these drugs is so rapid that there is no danger of a cumulative effect in using doses like these, and therefore no liability to sudden or great fall of temperature with cardiac depression.

At the same time the increased heat diffusion is very great, and the general principle of Brandt, of keeping the temperature continuously low, can thus be carried out.

The cold-pack, however, for the average case that will not stand the cold bath is doubtless decidedly preferable to this plan.

In the past few weeks I have subjected eleven cases in Bellevue Hospital to treatment by the cold-pack, and with very gratifying results. These patients all got well. They were all adults, only one as young as twenty years, and most of them made of the very poor material which seeks admission to our public hospitals in this city. In most of them the temperature was persistently high, and they came under treatment late in the disease—*i. e.*, after it had lasted between one and three weeks.

In a few instances the pack was kept up for fifty minutes, and ice was occasionally rubbed over the surface of the wet sheet which covered the patient. If, however, the method be persisted in, the patient being treated otherwise with care and discretion, it is usually not long, not more than a few days, before the temperature will remain habitually below 102° in response to a single pack in a day, and that of only a few minutes' duration.

It is a matter of greater importance than is commonly supposed that these patients should not be kept too warmly covered in the intervals between the packs. It should be borne in mind that we wish to increase heat diffusion as much as possible, and that this is to be promoted directly in proportion to the thinness and conductivity of the patient's covering. Under no circumstances should a fever patient have any more covering than due regard to his comfort renders necessary; and his unaided sensations are not always a safe guide. In his obtuse condition he often thinks that he wants several blankets, when a little gentle persuasion will lead him to believe that he really needs but one.

On the whole, the method of treatment by the cold-pack has been more gratifying to me than that by the internal use of antiseptics; but I wish again to emphasize the importance of using it systematically and so frequently as to keep the temperature always below 102°.

REPORT ON OBSTETRICS.

BY ELIZABETH STOW BROWN, M.D.

Jaggard (W. W.) on Accidental Hemorrhage.—The paper treats of hemorrhage due to premature separation of the normally implanted placenta. Three typical examples of the condition have recently come under the author's observation, and these he describes with particular reference to causation and treatment.

Premature detachment of the normally implanted placenta is extremely rare and its occurrence has been denied. Out of 22,498 labors at Guy's Hospital, the anomaly was noted but three times, while in 156,100 confinements at the Rotunda in Dublin it was not observed at all. Goodell, in 1870, was able to collect only 105 cases.

The first case showed premature central separation of the normally implanted placenta, the effect of trauma, in a IV.-para at the eighth month. Severe internal and external hemorrhage followed, without rupture of the amnion. Expectant treatment was employed. Spontaneous labor occurred eighteen hours after the injury, with the delivery of a stillborn child.

In the second case, there was premature separation of the normally implanted placenta in consequence of hydatidiform degeneration of placenta, in a II.-para at the eighth month. Severe internal and external hemorrhage followed, without rupture of the amnion. Accouchment forcé was deemed necessary, with the delivery of a dead fœtus. Manual delivery of the placenta was required.

In the third case, there was central detachment of the normally implanted placenta, from trauma, in a primipara, at the seventh month. Severe internal and external hemorrhage occured, without rupture of the amnion. Artificial induction of premature labor by intra-uterine colpeurysis was considered expedient, and was followed by the spontaneous delivery of a dead fœtus. The patient recovered.

The diagnosis of detachment, completely or in part, of the normally implanted afterbirth, is of great importance. This diagnosis was based upon a number of particular facts—the history of pain localized in the abdomen following upon muscular exertion; the sudden, considerable, symmetrical enlargement of the uterus; the abrupt cessation of active fœtal movements; the

disappearance of the heart-beats, and the external hemorrhage. The relation of the head to the lower uterine segment, completely filling it out, and the absence of any body like the after-birth upon palpation of the convex vault of the vagina, negatived the notion of the placenta prævia.

The indication for treatment was also plain—the evacuation of the uterus, and the arrest of hemorrhage by the natural mechanism of contraction and retraction. —*Med. News*, Nov. 30, 1889.

Noteworthy Midwifery Case. — A primipara had a delivery normal except in that it was somewhat more rapid than is usual in a first birth. The child was a very fine one, but as it did not breathe the physician turned away to employ proper means of resuscitation. At the same time he instructed the nurse to lightly grasp the uterus, and carefully follow it down. The patient had one severe pain and the placenta was expelled. On examination, the secundines were found complete. There was no hemorrhage, no shock, no symptom of any kind to lead us to suspect that any thing had gone wrong. On further examination, however, the body was found absent from the hypogastrium, and vaginal examination showed complete inversion of the uterus. It was easily reduced, and the woman made an uninterrupted recovery. The writer calls attention in his case to the complete absence of shock, hemorrhage, cold sweats, or even severe "dragging" pains.—*Lancet*, Nov. 23, 1889.

Benson (C. Coleman) on Diagnosis of Early Pregnancy.—The writer claims that early pregnancy—that is, from the second week of conception—can be readily and harmlessly ascertained by the careful introduction of the uterine sound and digital touch. There will be lengthening of the body of the uterus with curving at one angle of it, near the opening of the Fallopian tube, either left or right; there will be flaccidity of the uterine walls, marked dilatation of the internal os, and also of the cervical canal, and plugging of that canal with a viscid mucus, due to congestion of the entire endometrium. Since the placenta is not formed till the tenth week, before which time it acts as a foreign body and thus sets up reflex disturbances of the gastric organs and nervous system, a uterine sound may be introduced without causing any impressionable disturbance to fœtal development; but after the tenth or eleventh week, when the placenta is formed, and the reflexes have ceased, a sound when introduced would reproduce the reflex disturbances, and might penetrate the decidua reflexa.—*Southern Clinic*, Dec., 1889.

Twins with One Placenta.—After the birth of the first child, on making an examination, the physician was satisfied that there was another child in the uterus. A short time after tying the cord of the first child, labor pains set in again, and the second child was soon born. The placenta was then delivered and it was found that there was but one for both children. The umbilical cord of each child was attached near the periphery, about equidistant in each case. The children were both girls, one weighing four pounds and the other four and a half.—*N. Y. Med. Rec.*, Oct. 26, 1889.

Hicks (J. Braxton) on Placenta Prævia.—The author believes that the early handling of these cases, and the general antiseptic management of midwifery cases, can rightly claim to have had much to do with the excellent results in these cases, in modern times. Within the last thirty years, the death-rate has fallen from thirty per cent. to somewhere near five per cent. The writer proposes the following rules of conduct deduced from his long experience:

1. After diagnosis of placenta prævia is made, we proceed as early as possible to terminate pregnancy.

2. When once we have commenced to act we are to remain by our patient.

3. If the os be fully expanded and placenta marginal, we rupture the membranes and wait to see if the head is soon pushed by the pains into the os.

4. If there be any slowness or hesitation in this respect, forceps or version are to be employed.

5. If the os be small and placenta more or less over it, the placenta is to be carefully detached from around the os; if no further bleeding occur we may elect to wait an hour or two. Should the os not expand, and if dilating bags are at hand, the os may be dilated. If it appear that the forceps can be admitted easily, they may be used; but if not, version by combined external and internal method should be employed, and the os plugged by the leg or breech of fœtus. After this is done the case may be left to nature, with gentle assistance, as in footling and breech cases.

6. If the os be small, and we have neither forceps nor dilating bags then combined version should be resorted to, leaving the rest to nature, gently assisted.

7. If during any of the above manœuvres sharp bleeding should come, it is best to turn by combined method in order to plug by the breech.

8. Where the fœtus is dead, or labor occurs before the end of the seventh month, combined external and internal version is the best method, no force following.

To these rules may be added the observation : if a routine method be employed in all cases, it will be found that the version by combined method, no force following, gives a result as good, if not better, than any other.

The after-treatment must be conducted on the modern principles. Should oozing occur after the expulsion of the placenta, the swabbing of the lower uterus by styptics will be easy ; and inasmuch as the outlet of the uterus is liable more especially to be blocked by adherent clots, it will be wise to irrigate the uterus daily with some antiseptic solution or insert iodoform pessaires in the vagina, particularly if the irrigation cannot be done.—*Brit. Med. Jour.*, Nov. 30, 1889.

REPORT ON DISEASES OF CHILDREN.

BY ELIZABETH STOW BROWN, M.D.

Money (Angel) on Fulminating Pyo-Hæmothorax in an Infant Aged Eight Months.—The rarity of this affection in infants under the age of twelve months, and the difficulty of distinguishing it at the outset from simple intense bronchopneumonia, constituted the reason for the publication of the following case.

The patient was an infant of four months, who had been suffering from a catarrh four or five days before the severe symptoms developed. The night before the physician was called the child slept soundly, her temperature was normal, and her respiration was 24. The next morning, before nine o'clock, the breathing varied from 56 to 72, and the expiratory sound was panting, with a well-marked pause between inspiration and expiration. The temperature was 104.2 ° ; the lips pale and slightly blue ; the alæ nasi working, but not the sternomastoids ; the pulse was 168. The child screamed at the slightest touch, and especially when lifted up in such a way as to stretch the trunk ; the right back and side were harder than the left ; there were dulness, tubular breathing, and a sharp râle at the base behind. The case progressed from bad to worse, and three days later matters seemed to be rapidly coming to an unfavorable climax. The whole of the right side was dull, and there were dulness and crepitation over the left lower lobe. The next day twelve ounces of a sanguinolent fluid were withdrawn by aspiration. For a few hours the child grew easier, but later grew worse again. The aspirator was used again with marked temporary relief, and with the further withdrawal of a few ounces of the same sanguinolent fluid. It was evident from physical examination that air had gained access to the pleura, and that the lung was compressed. When the symptoms had again become serious, the thorax was laid open, and the pressure was relieved. For a time there was a slight improvement, but the next day the vomiting and diarrhœa became more frequent, the brain again began to fail, the anterior fontanelle sank, and the child died.

On autopsy, it was found that the lower lobe of the left lung was consolidated—"*collapse-pneumonia*" over its lower half. The right lung was much reduced in size, and occupied the groove by the side of the vertebræ ; its substance was hard, and collapsed in the upper half, but friable and evidently pneumonic in the lower half. On section, muco-pus was seen in the tubes, and several small collections of pus were in the periphery of the consolidated lower lobe ; one of these was in direct communication with the pleura by means of a widely patent fistula. The whole of the pleura was lined with a grayish-yellow lymph, and the subcutaneous and muscular tissues of the thoracic wall were infiltrated with sanguinolent serum.

The history of the case was most probably this : After a catarrh severe bronchopneumonia set in, and in places proceeded to the formation of small abscesses ; one of these burst into the pleura, and set up pyohæmothorax of fulminating intensity.—*Lancet*, Aug. 31, 1889.

Love (I. N.) on Acetanilide in Pediatric Practice.—The author reports his experience of eighteen months with acetanilide. He has employed the drug for many of the febrile, spasmodic, and

painful disturbances of childhood, and upon six hundred children. His conclusions are that :

1st. Acetanilide, carefully guarded and properly used, is a safe and reliable remedy in the diseases of infancy and childhood.

2d. As an antipyretic, analgesic, or sedative, it is preferable to antipyrin, in that the result secured is of longer continuance, and the depression is not so great.

3d. The cyanosis which sometimes results is not uniform, soon passes off, and is not accompanied by danger.

4th. As an antipyretic, acetanilide should be given in medium doses to the extent of keeping the temperature down to a reasonable point, in the neighborhood of 100° F. It is better to give small doses frequently than large ones at long intervals.

5th. It is of great value as an antipyretic.

6th. It serves almost as a specific in whooping-cough, not in aborting the disease, but in mitigating the discomforts and controlling the paroxysms of the same.—*N. E. Med. Monthly*, Aug. 15, 1889.

Wendt (E. C.) on Recent Views Regarding the Pathology and Treatment of Pertussis.—The writer reviews recent pathological studies of pertussis, and gives several plates of the bacillus. In his opinion the bacteriological researches of the Russian observer, Afanasieff, are far more important and convincing than any hitherto undertaken. Dr. Wendt's experience with the bacillus of Afanasieff leads him to think that it is probably always present in pertussis. He is, however, unable to confirm the assertion of the Russian that the small pellet of mucus which is coughed up at the end of a paroxysm contains the pertussis bacilli in almost pure culture. He has invariably found other varieties of bacteria (such as commonly occur in the sputum of bronchitis) along with those of whooping-cough. The writer cannot agree with Semchenko in ascribing any great diagnostic significance to the discovery of these bacilli in a given case, since he has not been able to demonstrate the bacillus pertussis, except in those cases where the clinical features of the disease were already so well marked that a microscopical confirmation was not needed.

The author mentions the use of antipyrine in pertussis as very successful in his personal experience. The drug has appeared to favor an easy course of the disease to final recovery, a mitigation of the paroxysms, especially at night, and certainly a freedom from complications. Dr. Wendt follows the directions of Sonenberger (who first recommended its use) in giving one seventh of a grain to very young children, and gradually increasing the dose according to the age of the child. The drug is given three times a day, and once in the night. It is administered in water and raspberry syrup, and is continued throughout the attack.—*The Med. News*, June 2, 1888.

REPORT ON DISEASES OF THE EYE AND EAR.

BY A. T. MUZZY, M.D.

Taylor (S. J.) on a Frequent Source of Fallacy in Ophthalmoscopic Diagnosis.—This fallacy is the mistaking of astigmatism for commencing neuro-retinitis. Such mistakes are very liable to be made by physicians and others who content themselves with a superficial knowledge, because these are usually satisfied with the indirect method of examination. The appearances are certainly very deceptive, for owing to the difference in focus of the two principal meridians, one meridian is hazy when the other is distinct. If the condition be that of hypermetropic astigmatism with some tortuosity of the vessels, which is not uncommon, with some congestion from eye-strain, the deceptive appearances are still more marked. Retinoscopy and the direct method will prevent a wrong diagnosis of beginning neuro-retinitis.—*Brit. Med. Jour.*, Nov. 9, 1889.

Accacio da Gama (J.) on Cataract Operation without Iridectomy.—The iris is fully dilated the day before the operation ; corrosive sublimate solution is the antiseptic used. The regular steps of the Graefe incision are interrupted to make a vertical incision of the capsule. The lens is then urged out by pressure and counter-pressure of the finger and spatula. The patients walk from the operation table to their bed. The eye is subsequently inspected and atropine used, every twenty-four hours. By this method eighty-six cases were successfully operated on at the Bombay Eye and Ear Infirmary, and forty-four in private practice. Cocaine was the anæsthetic employed.—*Brit. Med. Jour.*, Nov. 16, 1889.

Minor (J. L.) Remarks on Syphilitic Iritis.—This iritis usually comes on without any external cause. Its relation to the general disease can generally be easily traced, in many cases the appearance of the eye being a positive indication of syphilis. Hereditary syphilitic iritis usually comes on about puberty ; and is then often associated with inflammation of the cornea, sclera, or ciliary body, and is apt to affect both eyes together.

The iritis of acquired syphilis usually comes on during the secondary stage, though with many exceptions. The distinguishing symptoms are the appearance a few days after the onset of trouble of one or more nodular formations in the tissue of the iris of yellowish-red color, with its network of blood-vessels ; and we have to do with a gummatous formation. These formations may become of such a size as to encroach a good deal on the anterior chamber and the ciliary body. They usually subside by reabsorption under proper treatment. These formations differ from tubercular ones in their larger size, their color, and in that the tubercular are in larger number.

Treatment is both general and local. The local may with advantage be preceded by depletion by cup or leeches.—*Memphis Jour. Med. Scien.*, Nov., 1889.

Hamilton (T. K.) on Two Cases of Rupture of the Sphincter of the Iris.—Rupture of the sphincter iridis is not very common, though Hirschberg says it occurs in all cases of traumatic mydriasis. In both there was complete blindness of the affected eye for a few days following the injury. The patients were not seen until eighteen months after traumatism in the first case and ten years after in the second. The notes of especial interest in each case are :

Case I. (1) The entire absence of any injury to the exterior of the eyeball. (2) The absence of consecutive dilatation of the pupil. (3) The radiating striæ in the lens.

Case II. (1) The absence of any external injury here too. (2) The absolutely clear condition of the cornea, lens, etc. (3) The existence of vision nearly equal to that of the other eye ; this after so grave an injury is remarkable.—*Austral. Med. Gaz.*, Sept. 1, 1889.

Palmer (A. C.) on the Importance of Examining the Ears in Troublesome Coughs.—About two years ago a patient forty-five years of age was brought to me suffering from a nearly continuous cough with little or no expectoration. After careful examination of the chest and larynx, accident led to the examination of the ears, when there was found decided inflammation and intense hyperæsthesia of the drum membrane, every touch or even draught of air bringing on a paroxysm similar to such as he had been suffering from. All other treatment was now suspended, and under the proper treatment for the local trouble the cough entirely disappeared. At the present time two cases affected by eczema of the external canal with inflammation extending down to the drum have a more or less disagreeable cough. In one this has been sufficient to lead to frequent consultations for a supposed lung trouble.—*North Carol. Med. Jour.*, Nov. 1, 1889.

Richardson (C. W.) on the Possible Danger of Injury to the Middle-Ear Cavity by the Use of Nasal Atomization.—Six cases, three of my own and three already reported by Dr. Ring in the *Medical Record* of Aug. 11, 1888, lead to a warning against the careless and too free use of the spray in retro-nasal fossæ. The instruments used have been Davidson and Snowden's atomizing tubes and Roosa's belt nasal inhaler.

Politzer estimates that the pressure made by his air douche reaches as high as half an atmosphere or one half pound. But that only .1 of a pound pressure is necessary to force the air into the middle ear. Now the usual pressure employed in atomization is from 10 to 25 pounds. It has been taken for granted that the open nostril and even naso-pharyngeal connection prevented any of this force from penetrating the Eustachian canals. But these six cases and three others show that where there is only partial obstruction of the nasal openings, even spasmodic contractions of the soft palate and palate muscles may cause in any case penetration of the spray into the Eustachian canals and the middle-ear chamber beyond. In the last cases just referred to this penetration of the spray into the middle ear was clearly proven. The patients had perforations of the lower anterior portions of their drum membranes. And through these openings it was demonstrated, by reversing the usual order and spraying after inflation, the sprayed fluid entered easily the tympanic chamber. Boric powder was moistened in one case and in another the fluid was extracted and tested. — *Jour. Amer. Med. Assoc.*, Nov. 30, 1889.

REPORT ON DISEASES OF THE SKIN.

BY CONDICT W. CUTLER, M.D.

Shoemaker (J. V.) on Diet in the Treatment of Diseases of the Skin.—As the state of the skin's nutrition is an index to that of the organism generally, we are led to perceive that whatever promotes the general nutrition promotes at the same time that of the skin, and as the health of all tissues depends upon an appropriate supply of pabulum, the skin can be no exception. One needs to study the functions of the alimentary canal with as much care in the treatment of eczema, urticaria, or acne, as in that of the many forms which indigestion may assume. We frequently find that derangement of the digestive organs is productive of diseases of the skin. Proper diet in many cases of skin diseases is more important than constitutional treatment or local applications. In urticaria, eczema, and erythema simplex we can frequently trace the connection between a derangement of digestion and the cutaneous malady. The loaded tongue and other symptoms of acute dyspepsia point toward the cause of the disorder, and an emetic or purgative, or both combined, will frequently bring speedy relief. In urticaria, articles of food which have been known to cause previous attacks should be prohibited, and only small quantities of animal, fatty, starchy, or saccharine food be taken. Alcoholic liquors should be forbidden. Gastro-intestinal derangement is a frequent cause of eczema by the absorption of waste products and defective excretion, In acute eczema, where large extent of surface is involved, the diet should be bland, such as milk, rice, arrowroot, tapioca, toast, etc. When it occurs as a complication of gout, all alcoholic beverages should be prohibited and very little meat allowed. When it occurs with rheumatism, all articles which readily undergo fermentation should be used very sparingly. Scrofulous patients require fat, meat, and liberal sustenance, excluding starches.

Patients affected with acne generally present evidences of impaired nutrition, and attention to the diet is most important, and, as a rule, nutritious food is required. Rosacea is generally developed as the result of incomplete digestion or the presence of alcohol in the blood. The food should, therefore, be simple but nutritious, and alcoholic beverages forbidden. Purpura is frequently caused by improper food, and requires a diet of milk, fruit, vegetables, etc. Herpes zoster calls for a diet of fatty articles of food, as cream, butter, oil, etc., and the same is true of ichthyosis. Lichen planus, sycosis, pityriasiskrubra, and the pustular skin diseases are usually associated with faulty nutrition, and require a liberal diet of easily-digested foods. The eruptive fevers are best treated by a strictly fluid diet, especially milk, during the acute stages.—*The Dietetic Gazette*, Oct., 1889.

Bulkley (L. D.) on the Value of Natural Mineral Spring Water in the Treatment of Skin Diseases.—According to the author, most of the waters had little effect upon the skin, but touched especially the kidneys, liver, bowels, etc. We could not always predict the effect of the water from its chemical analysis. Sometimes cutaneous diseases depending on debility were improved. Everybody had seen cases of eczema which had been treated at the sulphur springs in vain. Where there was a rheumatic element back of the cutaneous lesion no doubt some good could be received, but in those cases it was the alkaline water and not the sulphur which was of benefit.

Like all other remedies, the use of springs must be carefully prescribed in order to be of the greatest use. Probably more benefit was derived in eczema than in other diseases, and even then it should be toward the close of the case. First should be used the alkaline and moderately purgative waters, and then a tonic course. Carlsbad was advisable where there was much abdominal plethora. In acute cases the hot springs should be used. Care must be taken lest acute eczema be excited by the springs, for some very severe cases had been lighted up in this manner. In psoriasis sometimes sea-bathing was of far more benefit than the mineral springs. In syphilis little benefit followed unless other treatment was kept up. Acne would often be benefited somewhat, and the iron springs were better than the sulphur.—*New York Med. Jour.*, Nov. 2, 1889.

Max on an Epidemic of Pemphigus.—An epidemic of pemphigus has recently occurred in Brussels affecting young children from two days to thirteen months of age. The eruption appeared

generally on the abdomen and thighs, but never on the palms of the hands or soles of the feet. Red patches first appeared, and on them, soon afterward, bullæ, varying in size from a lentil to a walnut. The contents of these bullæ remained clear unless the general health of the subject was bad, when it became purulent. The treatment consisted in picking the bullæ and dusting them over with starch or subnitrate of bismuth. Although a special bacillus of pemphigus has been described by Gibier, Vidal and Colzat have demonstrated that adults can be inoculated with the liquid in the bullæ; no case of transference to an adult was observed.—*The Lancet*, Oct. 19, 1889.

Destot on the Inoculability of Psoriasis.—Dr. Destot made the following experiment upon his own person: On the 9th of May he made an incision in the skin over the right deltoid muscle, and inserted a complete plaque of psoriasis removed from the arm of a child. Two days afterward papules appeared upon the left elbow and subsequently upon that of the right, which took on, some days later, the most decided characteristics of psoriasis. The diagnosis of psoriasis was confirmed by the members of the Society of Medical Sciences of Lyons, before whom Dr. Destot presented himself. Before the experiment Dr. Destot had shown no traces on his body of any psoriatic eruption. This observation would tend to demonstrate the parasitic theory of Lang as to the cause of psoriasis.—*Jour. of Cutaneous and Genito-Urinary Diseases*, Dec., 1889.

Burns on Curative Effects of Erysipelas on Tumors.—Burns has collected twenty-two cases of tumors which were the seat of idiopathic erysipelas. Three cases of sarcoma were permanently cured. Two cases of multiple keloid following burns were completely cured. In four cases of lymphoma of the neck, some of the glands entirely disappeared and the others became smaller. In five cases erysipelas was artificially produced. Three of these cases were carcinoma of the breast. In one of them the disease was not checked, in another the tumor was diminished to one half its size, and the third was practically cured, a small induration in the scar, the size of a pea, remaining. A multiple fibrosarcoma was diminished in size, and an orbital sarcoma was unchanged.—*Cincinnati Med. Jour.*, Dec., 1889.

Brocq (L.) on Treatment of Psoriasis with Large Doses of Potassium Iodide.—Haslund of Copenhagen first advised the use of large doses of iodide of potassium for the cure of psoriasis. Great success from this treatment is reported from that and other countries, but in France the result has not been satisfactory, probably because large doses have not been well tolerated. In Paris, however, Dr. de Molènes has had great success in following out Haslund's method. Very large doses, however, had to be administered. One patient took, in increasing doses, 1,117 grammes of iodide of potash in nine weeks; a second, 1,751 grammes in forty days. He advises, when such large doses are taken, to very carefully watch the stomach, intestines, and kidneys.—*Jour. of Cutaneous and Genito-Urinary Diseases*, Dec., 1889.

Leblond on Treatment of Chancroid with Resorcin.—Dr. Leblond's plan of treatment consists of sprinkling powdered resorcin each day on the chancroid, and gently cleaning the surface the following morning. So long as the base of the sore has a grayish color, he continues the application. This usually takes five or six days; afterward he washes the sore and dresses it with a five-per-cent. solution of resorcin. This plan of treatment transforms a contagious inoculable sore into a simple wound, prevents adenitis, unless it has already formed, when it usually prevents suppuration. If suppuration has taken place, the bubo is opened, irrigated with a five-per-cent. resorcin solution, and then dressed with resorcin powder.—*Jour. of Cutaneous and Genito-Urinary Diseases*, Dec., 1889.

Grindon (J.) on the Etiology of Alopecia Areata.—One school of dermatologists holds that alopecia areata to be a pure trophoneurosis, while another considers the disease to be due to some vegetable parasite, and consequently contagious.

The American school quite uniformly holds to the former opinion. Thus Duhring says: "It is non-parasitic in its nature, and is not contagious. The origin is beyond doubt to be found in a peculiar functional nerve disturbance, causing impaired nutrition."

Van Harlingen says: "Two theories have for some years past divided dermatologists, the neurotic and the parasitic. Against the latter view we have the fact

that the clinical appearances presented by the disease are in no way like those of other vegetable parasitic skin diseases, and also that each discovery of fungus in the disease depicts a different variety from all previous observers. Finally, also, anti-parasitic remedies have no effect toward the cure of the disease."

On the other hand, Genby, in 1843, described a fungus consisting of spores and mycelium, the former being small and scanty, and the latter present in great abundance, which he considered to be the cause of the disease. Many prominent French and English authorities, among them Bazin, Hardy, Hutchinson and Tilbury Fox, adopted these views. Thin, however, in 1882, described what he named bacterium decalvans, consisting of minute bodies of uniform size arranged end to end in twos or threes on the hair shaft or in the root sheath. After analyzing a great number of cases, the author concludes that under the name of alopecia areata are included:

(1) An affection or several affections due to the presence of parasites, which affection or affections must be rare in this country. (2) Cases symptomatic of some disturbance of innervation. These cases might well be included under the head of alopecia neurotica by somewhat extending the limits set by Nicholson in introducing the name.—*Brit. Med. Rev.*, Oct. 12, 1889.

Clarke on Ainhum, a Brazilian Disease.—Dr. Da Silva Lima first described this disease in the *Gaseta Medica de Bahia*, in 1867. This same disease was, however, previously described before the London Epidemiological Society as a dry gangrene of the little toe, occurring among the natives of the Gold Coast.

Ainhum consists in hypertrophy and degenerative changes in the little toe, a constriction forming and slowly becoming deeper until the digit is amputated spontaneously or otherwise. The disease is often symmetrical, and may last for years. It is now known that the fourth, or even the great toe, may be affected, and Egles describes a case where a finger was attacked. It is frequent near Bahia, and also occurs in the Southern States of America, the West Indies, the West Coast of Africa, India (where Hindoos are also liable to the disease), Réunion, and Nossibé. M. Cogues has described a case of ainhum, which occurred in Madagascar, in the March number of the *Archives de Médecine Navale*. The pathology of ainhum is obscure, and although spontaneous amputation of digits is a feature in some forms of leprosy, it is by no means certain that the two diseases are closely allied.—*Brit. Med. Jour.*, Nov. 23, 1889.

Rosenburg on the Treatment of Leukoplakia.—In all remedies used in the treatment of leukoplakia the balsam of Peru holds first place. It not only checks the pain and heals the lesions denuded of epithelum, but clears up cloudy epithelial patches, and causes deposits to disappear. Two things are necessary—protracted application and a pure preparation of the drug. When fissures are present and the epithelum denuded, the balsam is to be applied gently with a brush, but otherwise a stiff brush is to be thoroughly used, so as to act in a degree mechanically. The application should be made three times a day, and kept in contact with the lesions for at least five minutes at a time.—*Edinburgh Med. Jour.*, Dec., 1889.

Schuster on a New Treatment of Favus.—The treatment consists in the use of dry sulphurous acid gas. A pasteboard cylinder twenty inches high is made, open at both ends. The lower portion fits over the head as far as the forehead; the upper can be closed by a well-fitting pasteboard cap. A stage, made by stretching across pieces of string, is formed at the level of the lower third, the holes in the cylinder being closed by a piece of paper pasted on. On this stage a saucer containing sulphur can be placed. When in use the cylinder is put on the head of the patient, and secured by an india-rubber band, or by a bandage, so as to be air-tight. Through the upper opening a saucer containing burning sulphur is let down till it rests on the stage of threads of string, and the cover is put on. The patient remains sitting quiet for half an hour. The space contained within the cylinder is thus filled with sulphurous acid fumes; the sulphur becomes extinguished on the exhaustion of the contained oxygen. At the expiration of six or eight weeks of this treatment, which is repeated daily, the scalp is quite free from disease, the previously diseased parts have become smooth, white, bald places. While this is done the hair must be kept short, the crusts softened by means of oil, and the hair kept clean by soap and water. He suggests that this plan might also be

found applicable to tinea tonsurans of the scalp.—*Monatshefte für praktische Dermatologie*, Band ix., Heft 1, 1889. *Edinburgh Med. Jour.*, Dec., 1889.

Bulkley (L. D.) on the Value of Arsenic in the Treatment of Bullous Skin Diseases.—In bullous skin diseases, especially those of a chronic character, occurring in children, arsenic is a valuable remedy. As a rule, arsenic acts with them as a purgative before it manifests its other physiological effects, and it may generally be safely given in bullous eruptions in increasing doses. If the disease does not yield, it may be increased till it purges; then the dose should be slackened to a point where it is perfectly borne. In regard to the action of arsenic, he quotes Mr. Hutchinson. "Arsenic does not merely repress the eruption, but remedies the unknown constitutional causes on which that symptom depends, always very much benefiting the general health of the patient. Arsenic does not prevent the liability to subsequent attacks, but such attacks are always much less severe than the original one, and tend, if treated by the same remedy, to diminish in intensity on each successive occasion." He administers the arsenic in many cases every two hours, and thus being taken apart from a meal at times it must be well diluted, at least in a third of a tumblerful of water. Vichy water is an excellent medium, rendering it more readily borne by the stomach, and sometimes also increasing its efficacy.—*N. Y. Med. Jour.*, April 13, 1889. *Edinburgh Med. Jour.*, Dec., 1889.

Treatment of Epithelioma by Potassium Chlorate.—Lemoine (*Monatsh. für prakt. Derm.*, vol. viii., No. 4) believes that in potassium chlorate we have a remedy which has great curative properties, and which may even bring about a complete cure. He specially recommends it in cases in which epithelioma occupies the skin and the adjacent mucous membrane, when the knife is not applicable. As the effects are slight, it is not to be tried in cases where the disease is making rapid progress.—*Cincinnati Med. Jour.*, Dec., 1889.

Pontain on Treatment of Buboes by Injections of Iodoform in Vaseline.—The following is the manner in which Professor Pontain proceeds: 1. Washing and antisepsis of the region by means of Van Swieten's liquid, diluted one half with hot water. 2. Puncture with the lancet if the skin is soft, with the straight bistoury if the pus is deeply situated. The puncture is small and made in the most fluctuating point; it is not necessary that the incision have a slope, for there will be no discharge in the next succeeding days. 3. Evacuation of the pus, pressing out completely all the liquid contents of the ganglion; it is indispensable to cause all that the ganglion contains to be gently and gradually pressed out, and this procedure is sometimes painful. A few injections of diluted Van Swieten's liquid are now made to wash out well the pouch. 4. Injection of iodoformized vaseline melted by heat; it is to be pressed gently in by means of a glass syringe previously charged and placed in hot water. 5. Dressing with absorbent cotton. As soon as the cavity is full of the iodoformized vaseline, a wad of cotton, soaked in cold Van Swieten's liquid, is placed over the adenitis, and kept in place with a spica. The contact of the cold congeals the vaseline, and makes a plug at the orifice of the bubo. After the first day all pain disappears, and ordinarily healing is complete without cicatrix in an average of six or seven days. It is at times necessary to renew the injections of vaseline. Out of forty-one buboes thus treated by the author, more than half were cured in less than five days. The most rebellious required twenty-three days.—*Jour. of Cutaneous and Genito-Urinary Diseases*, Dec., 1889.

REPORT ON THE DISEASES OF WOMEN.

BY JOHN S. HAWLEY, M.D.

Gross (F. H.) on Two Cases of Hæmatometra.—In these cases, atresia existed; in one, at the lower end of the vaginal tube, while in the other it consisted in an obliteration of the cervical canal of the uterus; and thus were exemplified two interesting varieties of the occlusion.

The first patient was in her fourteenth year, and therefore at the age of puberty; but she had never menstruated—that is to say, no visible signs of the catamenial flow had been noticed. The first disturbances of her health had occurred about six months before, and, although she never felt quite well afterward, her indisposition for a time caused no apprehension. But a number of

subsequent paroxysms of augmented severity attracted anxious attention. Examination of the vulva revealed protruding therefrom a smooth and very tense swelling, in which the experienced touch could readily detect fluctuation. Neither the examining finger nor the probe could find anywhere between this protrusion and the labia an entrance to the vagina. The hypogastrium had become prominent from a tumefaction, which arose from the pelvis. This enlargement in the course of its development had been noticed to be most sensitive during the paroxysmal attacks, which were doubtless the regular menstrual molimina. There were symptoms of a subjective character, such as headache, giddiness, nausea, and other gastric distress, a feeling of painful fulness in the abdomen, palpitation, and disturbed vision which the prescribed glasses of the oculist had failed to relieve. This complex of distressing and long-enduring symptoms was sufficiently pointing to lead to the diagnosis of hæmatometra as a contingent upon atresia hymenalis. The hymen was punctured with a trocar, and after thirty-two ounces of chocolate-colored fluid had been withdrawn, the opening was enlarged by a crucial incision. The uterus remained out of reach, so the vagina was washed out with a weak solution of mercuric chloride, and a pad of antiseptic gauze placed over the vulva. An abdominal binder was applied to keep up gentle pressure on the hypogastrium. Relief was immediate, and in four weeks' time normal menstruation occurred, and the flow has regularly recurred since that time.

The second case was that of a woman, forty years of age, twenty years married, but sterile. In May, 1888, the catamenia, previously normal, became scanty and painful in character; and in August of the same year the flow did not appear. Amenorrhœa for the following eight months; attacks of lumbar pain and of uterine colic at the periods when menstruation should have appeared, these symptoms growing progressively more severe in character; retention of urine and abdominal enlargement were developed, and, when examined during the latter part of March, 1889, the presence of a large, smooth, and hard tumor, situated low down in the pelvis, and presenting no vestige of a cervix or os uteri was apparent. The diagnosis of hæmatometra was made from the history, and the mass was punctured with a trocar, the characteristic fluid being withdrawn. The opening was enlarged, and the uterine cavity washed out with a solution of bichloride of mercury, and rapid recovery ensued, several menstrual periods occurring subsequently. The condition was due to stenosis of the internal os and adhesion of the walls of the cervical canal.—*Cincinnati Lancet-Clinic*, Oct. 19, 1889.

Edes (A. W.) on Epithelioma of Clitoris.—The patient was unmarried, aged 43, and had had the growth for five years. The tumor was about as large as an almond, and was not accompanied by enlargement of the inguinal glands. It was removed by the cautery-knife, and no recurrence had been noticed after four months' interval. In a similar case implication of the inguinal glands was found, the lesion having been treated for a year as a chancre.—*Brit. Med. Jour.*, Nov. 2, 1889.

Hollister (J. H.) on Acute Inversion of the Uterus.— The uterus, whether gravid or not, may become partially or completely inverted as a result of enlargement and distension, this being due to the growth of a fœtus or a tumor. Force, either traction of a pendulous growth, or of an adherent placenta partially extended from the cavity of the uterus or pulled upon by traction on the cord by the attendant, is necessary in the production of inversion of the fundus, which is never inverted by contractions of its own muscular fibres. When the inversion is complete the os uteri is not discernible, but the inverted cervix is felt as an easily distensible band. Hemorrhage is not troublesome when the inversion is complete, but profuse when induction has been partly effected. The histories of two cases of the condition in his own practice bore him out in these statements.—*Med. News*, Nov. 16, 1889.

Van de Warker (Ely) on Sloughing Intra-uterine Fibroids.—From an analysis of the histories of five cases, the following conclusions are drawn:

1. That the use of the curette to remove the sloughing periphery of an intra-uterine fibroid is justifiable when it is non-removable from any complication, or in cases of extreme exhaustion that render extirpation extra-hazardous.

2. That the process of sloughing begins at the outer layers of the mass and extends layer by layer into its deeper structure.

3. That rapid dilatation of the cervical canal affords ample space for the manipulations of removal; and that sponge tents and other slow methods of dilatation are unnecessary.

4. That fibroids, formerly intra-uterine, when extended from the uterus and pendulous in the cavity of the cervix with its pedicle therein attached, were rarely found in a sloughing condition.

5. That a form of hystero-tetanus, without trismus, might follow either certain forms of blood-poisoning or uterine lesion. Within the experience of the author this condition, only met with in the puerperal state, was attended with septicæmia.

6. That blanched mucous membranes, in excessive and long-continued blood loss due to intra-uterine fibroids, afford a certain indication that the limits of safety have been reached in operative treatment of sloughing fibroids, and that a doubtful prognosis must be given.

7. That septicæmia with long-continued pyrexia is necessarily a fatal condition when due to a sloughing fibroid, unless relieved by the removal of the offending mass; that removal, wholly or in part, is a life-saving operation and is imperative; that the operation is comparatively easy and attended with but little danger, except in cases of blanched mucous membranes. —*Boston Med. and Surg. Jour.*, Nov. 7, 1889.

Engelmann (Geo. G.) on Renal Disturbances Caused by Disease of the Pelvic Viscera.—Those especially considered by the author are the forms due to compression of the ureter. This may result from the presence of malignant growths, inflammatory deposits, from displaced organs or neoplasms. Occlusion of the lumen of the duct may be caused by septic or gonorrhœal inflammation of the mucous membrane; or circulation and secretion may be disturbed by reflex nervous influences or perverted nerve action from the intimate relation of the renal and uterine plexuses, pregnancy, etc. The progress of these cases is very slow, and the condition may not be suspected until dangerous symptoms appear. The prospect of affording relief depends upon the causative condition and the possibility of removing the same. The urine may be normal in unilateral obstruction of the ureter, and give no hint of the trouble when œdema, etc., are present. The ureter when distended may sometimes be palpated through the abdominal wall, but if the obstruction is above the pelvic brim the intra-pelvic portion is not changed. The affected kidney is to be relieved by removing the obstruction by catheterizing the ureter, dilating its canal, or opening into this above the point of obstruction when this is low down. If the ureter cannot be cleared, the kidney must be reached from above, opened and drained, and concretions be removed. As a last resort, nephrectomy may be done.—*Boston Med. and Surg. Jour.*, Nov. 7, 1889.

Byrne (John) on Treatment of Cancer of the Uterus by Galvano-Cautery.—The results of this method of treatment in 367 cases, 121 of which had been lost to observation before the end of the first year after operation. In fifty-nine cases the vaginal portion of the cervix alone was involved. Of the cases kept under observation the average period of exemption from recurrence was eight years and seven months. In eighty-one cases in which the entire cervix was affected the average period of exemption was five and a half years, and in eight cases in which the disease was confined to the body of the uterus the average was two years. The diseased tissue is to be removed as completely as possible by the galvano-caustic loop, then cauterize the mucous membrane of the uterus with an instrument which is to be introduced cold, and then heated by the current, and finally to thoroughly cauterize the stump of the cervix. The parts must be wiped very dry when the cautery is applied, and this should always be introduced when cold, and the current not turned on until the instrument is *in situ*, touching the tissues which are to be destroyed. The cauterization must be very thorough, and should be repeated at the slightest sign of recurrence. The author did not claim for the operation more than the affording of long-continued relief—not absolute cure—and the almost complete freedom from danger in its employment. He was strongly opposed to hysterectomy, believing it to be no more effective—even if equally so—than his method, while it is infinitely more dangerous.—*Boston Med. and Surg. Jour.*, Oct. 31, 1889.

Mundé (Paul F.) on the Nature and Limitations of the Surgical Treatment of Uterine Fibroid Tumors.—From a study of the histories of six-

ty-two cases demanding surgical treatment, the author concludes as follows:

1. Fibroid growths of the uterus situated near the fundus uteri and showing no tendency to downward development, if requiring active treatment, are best reached from the abdominal cavity.

2. Tumors situated near the internal os and under the influence of oxytocic measures, or of their own accord showing an inclination to dilate that orifice and encroach upon the cervical canal, can almost always, after due preparation, be removed safely per vaginam.

3. About one half of all fibroid tumors, which come under the observation of the physician, require no active treatment of any kind.

4. Only rapidly growing subperitoneal or interstitial tumors call for or are benefited by galvanic treatment.

5. The removal by the sharp curette of the hypertrophied mucous membrane of the uterine cavity will often, at least temporarily, relieve the menorrhagia which is the chief symptom caused by the interstitial variety.

6. Enucleation, after splitting the capsule by means of traction by the finger and some blunt instrument, offers a safe means of cure in cases of interstitial, cervical, and submucous corporeal tumors. Certain interstitial tumors, which are so situated as not to be affected by the pressing influence of ergot and influencing the general health by profuse uncontrollable hemorrhages, and certain cases of rapidly growing subperitoneal tumors, in which a thin pedicle cannot readily be formed, may require the removal of the ovaries to check the hemorrhage and the growth of the tumor.

7. Laparo-hysterectomy should never be performed merely to relieve the patient of a fibroid tumor, which does not affect her general health and is merely inconvenient or unsightly.

8. The nearer the menopause the less likely is the fibroid to grow or cause trouble, and, therefore, other things being equal, less likely to call for active operative measures.—*Boston Med. and Surg. Jour.*, Oct. 31, 1889.

Page (K. B.) on Hæmatoma of the Vulva in the Non-Puerperal State.—Three cases of this uncommon condition had been observed by the author, who gives the histories in detail. All were caused by direct violence: in one from a fall astride the rung of a ladder; in one from a kick in the vulva, which was at the time the seat of the chancroid; and one caused by a fall against the corner of an ice-box, when the legs of the patient were widely separated. In the first case the tumor was small, was promptly treated, and the patient was relieved by applications of ice and mild counter-irritation subsequently. In the second case, the patient passed from under observation, the tumor ruptured spontaneously, and the wound became inoculated with chancroidal pus, resulting in phagædenic ulceration of the parts and destruction of a large amount of vulvar tissue. The third case presented so large a tumor and infiltration of the cellular tissues of the thigh, perinæum, and mons veneris, that it was incised, its contents evacuated, and its cavity scraped and drained. The author would follow the last method of treatment after the use of cold applications has failed to arrest the increase in the size of the tumor, or when there are no signs of the absorption of the effused blood presented, and when the tension of the overlying tissues is so great as to threaten a spontaneous rupture of the tumor, that result being most undesirable. Rigid antiseptic precautions are indispensable.—*Times and Register*, Oct. 19, 1889.

Bantock (Geo. G.) on Ovariotomy.—The author, in reporting the results in 400 ovariotomies performed by himself, related his views regarding the mooted points of technique and after treatment in the light of his own experience. Antisepsis—*i. e.*, the use of chemical agents as germicides during operation—is unequivocally denounced, and cleanliness of hands, sponges and all instruments, utensils, etc., insisted upon. Plain water—not even sterilized by previous boiling—is the only fluid he uses, either for instruments, irrigation, or washing out the peritoneal cavity. The author cites as evidence of the evil influence exerted by antiseptic agents his own mortality percentage as follows: First one hundred cases, (all performed with strict Listerian precautions or modifications thereof) nineteen deaths; second hundred (Listerism being gradually abandoned), fourteen deaths; third hundred (all performed with use of plain water only), eight deaths; fourth hundred (same method), four deaths. Furthermore,

in the Samaritan Free Hospital the author did not lose one patient out of ninety ovariotomies, performed without the use of antiseptics, during three years and a half, while during the same time the mortality under the Listerian method exceeded 12 per cent. The dressing of the abdominal wound which he employs is simply a piece of plain absorbent gauze. He believes most religiously in washing out the peritoneal cavity whenever the contents of a cyst or blood from torn adhesions are effused within it, but protests against the use of any solution for this purpose, except possibly in cases where there has been much hemorrhage, when a little common salt may be added to the warm water. No great care to remove all of the fluid from the cavity is exercised, and much sponging for such a purpose is deprecated on the ground of danger of injuring the peritoneal surfaces. The pedicle, when at all broad, is secured by ligature, the outer edge, which sometimes slips from the grasp of the ligature having first been tied separately. If the pedicle is so thick and wide as to demand several ligatures or the "cobbler's stitch," it is first tightly compressed with strong forceps, and then ligated, this being done to anticipate shrinking and retraction of the tissues, and subsequent hemorrhage. Chloroform alone was employed for anæsthesia.

In the after treatment of the patient Dr. Bantock differs with Tait and Greig Smith as to the efficacy of saline cathartics in the treatment of peritonitis, holding that when such actually exists the only reliable treatment is surgical-reopening of the wound and drainage. The presence of fœcal accumulation in the gut, or of irritating matter may give symptoms identical with the early indications of peritonitis. He prefers large enemata as a means of clearing out the gut, as the almost constant symptom of vomiting precludes the use of saline cathartics in his opinion. He denies the influence attributed to the latter in promoting the absorption of morbid matter in the peritoneal cavity, and regards the known methods of treatment of peritonitis as very unsatisfactory. Vomiting is treated by withholding all administration of any thing by the mouth, sometimes giving sodium bicarbonate if much acidity is present, as evinced by the matter ejected. Ice should never be given for thirst, but the mouth is to be rinsed with warm water, which is the best of all things for relieving thirst.—*Med. Press*, Nov. 12, 1889.

Nowlin (J. B. W.) on the Use of Pessaries.—The objections to the employment of pessaries are thus summarized:

1. They can only act as palliatives. If too small they are expelled or cannot sustain the womb, and if too large, they exert injurious pressure.

2. They keep up continued irritation in the vagina, acting as a foreign substance, producing mucous, purulent, and leucorrhœal discharges, thus laying the foundation for fungous or cancerous diseases.

3. Many forms of these instruments are liable to produce septic results.

4. They produce undue and permanent dilatation of the vaginal walls by destroying the tonicity of the parts.

5. If not frequently removed they become filthy and irritating.

6. They are liable to cause irritation of the bladder and constipation.

7. Their application is often left to the laity.

8. By the obstruction which they offer to the circulation, they produce engorgement, and it may be ulceration of the surrounding parts, extending even to the production of a vesico-vaginal or rectal fistula.

Truer words were *never* uttered by any surgeon, and it would not be amiss could these objections be framed and hung in the *majority* of practitioners' offices, and the office of *every* gynæcologist. A pessaric reformation is coming and the muchly used instrument—so seldom needed—will be quite a thing of the past.—*Southern Practitioner and Cincinnati Med. Jour.*

[We have noted Dr. Nowlin's objections for the sole purpose of calling attention to the utter lack of reason in his argument, unless such be confined to the use of pessaries by the man who is incapable of understanding, selecting or fitting a pessary, but who uses it with no more judgment or discretion than do certain people the various patent nostrums which are vaunted in the daily journals. The man who inserts a pessary—being led to choose a particular model, because of the eminence as a specialist of the original designer thereof—without replacing or preparing the uterus for its presence, and the man who inserts a pessary at the first visit of his patient, giving her no directions as to

her future conduct in regard to removing or having it examined from time to time by the physician, are those who have the most bitter enmity toward the instrument, and get the disastrous results noted by the author. When the general practitioner once understands that a pessary must be fitted and applied to the case in hand after exactly the same principle as is followed in the use of plaster-of-Paris dressings in the treatment of fracture,—*reduction* of the fracture, proper condition of the soft parts, absolute freedom from pressure, on any part being afforded by care in applying the splint, and removal of the same at the first sign of trouble existing underneath it—the pessary will be appreciated, and the abuse which is now launched at it will be directed at the ignorant, clumsy, and incompetent man who ascribes the results of his own monumental malpractice to the innocent instrument which he has misapplied, and which he employs empirically. Not a single case of injury, infection, or other bad result from the use of pessaries can be cited in which either improper condition of the parts at the time of introduction, non-suitability of the form of the pessary to the requirements of the case, or inexcusable neglect on the part of physician or patient cannot be found as an explanation for the result, and the diatribes of those who are blind are a weariness to them that see when the former imagine a vain thing against the use of what they wot not the form or character by them who are wise and expert. Well-meaning divines denounce the drama,—they have never seen a play. Earnest moralists condemn the waltz,—they have never attended a ball. Enthusiastic reformers call for non-political civil service,—they have never held an office or "worked" at election time. Laymen of education are medical heretics, because they generalize from a single observation, and the one who does not know how to peel grape fruit tells all the world that the pulp is bitter in taste and of no flavor. The intelligent use of pessaries is an invaluable means of gynæcological treatment. The improper employment of the same is as unjust an index to their value as the amputation of the wrong leg would be when discussing the merits of the form of amputating-knife used in the operation. A single word is enough for the wise: he that is a not-wise should never use a pessary, and will alone decide against their employment in uterine displacements.—J S. H.]

DISEASES OF THE NOSE AND THROAT.

BY CHARLES H. KNIGHT, M.D.

Roberts (J. B.) on the Cure of Crooked and Otherwise Deformed Noses.—Perhaps the most interesting part of this paper is that relating to the treatment of septal deviation, in which the author again describes his own special method, which he candidly admits is not adapted to all forms of deviation. Very likely the poor results with it obtained by certain operators are due to its indiscriminate use. Attempts to correct a deflection by means of clamps or plugs result in only temporary benefit, since the resilient septum tends to assume its original position. Roberts' operation consists of first making a long incision at the most prominent part of the deviation, after which the septum is still farther broken up by the use of the stellate punch, a modification of Blaudin's. The crossing of incisions may result in loss of tissue and perforations, which are of no consequence, as they are very small and soon close. Bony projections from the floor of the nose, which appear after replacing the septum in the middle line, are chiselled off. Steel pins with flat heads or spherical glass heads are used to support the septum in position. The latter are better when the head of the pin is to go within the nostril, the former when it is to lie against the exterior of the nose. The important steps in the operation seem to be thorough destruction of the resiliency of the cartilage by multiple incisions and the method of passing the pins. The pin is passed into the more open nostril and through the anterior part of the septum which is to be replaced. The point of the pin is thrust onward and buried deeply in the tissues of the naris originally occluded and far behind the obstruction. The head of the pin should lie within the nostril against the columna and on the side originally free. It should not remain for more than a week, lest damage be done to the columna. If necessary this pin may be fortified by a second having a flat head and passed from the external surface at the junction of the nasal bones with the carti-

lage. Nasal plugs are not required, and the nostrils are left free for the use of antiseptic and cleansing washes. In some cases preliminary excision of an hypertrophied turbinated body may be necessary. Four per cent. solutions of cocaine will give all the anæsthesia needed for moderate operations. In the more prolonged operations ether is desirable.

In removing enchondromatous tumors of the septum the chisel or saw is often required, the centre of the mass sometimes being bony. It is well to first divide the mucous membrane at the lower limit of the tumor and thus avoid the difficulty met with in attempting to separate the soft tissues when the parts are obscured by blood and have lost the support which the cartilage gives before its detachment. The latter may then easily be removed from above downward. Transfixion of the mass with a barbed needle is a useful device in the absence of bony tissue.—*The Buffalo Med. and Surg. Jour.*, July, 1889.

Thrasher (A. B.) on Morbid Perforations of the Nasal Septum.—Sixteen cases are reported regarding which the following facts are observed.

1. A large majority of these cases of perforation of the septum were non-syphilitic.

2. The majority of the cases were giving rise to no trouble, and needed but simple local treatment.

3. The prognosis in every case was favorable, with treatment; in the majority of cases, favorable without treatment.—*The Cincinnati Lancet Clinic*, Oct. 26, 1889.

Ball (J. B.) on Intranasal Disease and Asthma.—In the majority of cases asthma is associated with nasal symptoms, and in many cases it may be cured by relieving the nasal condition. The author admits that recent observations tend to establish the foregoing proposition. As the exciting cause of hay fever or hay asthma he recognizes a variety of influences acting upon a highly susceptible nasal mucous membrane, among them mechanical irritants—pollen, dust, powders, etc.,—as well as mental impressions, an example of the latter being Mackenzie's well-known experiment with the artificial rose.—*The Practitioner*, June, 1889.

In the *Med. News*, Aug. 31, 1889, Dr. Beverley Robinson records a number of clinical observations and gives only modified assent to the nasal theory of asthma, as sustained by Bosworth. In only six out of thirty cases of asthma, intranasal obstruction existed, and in four at least temporary improvement followed removal of the nasal trouble.

Rumbold (T. F.) Five Reasons Why so Many Physicians Fail in Treating Chronic Rhinitis.—1. Defective instrumentation. The writer seems to have had the misfortune to meet with a class of practitioners, including those who have imbibed knowledge at Vienna and those who have struggled for the light at home, who are accustomed to using a tongue depressor so long as to produce retching, or so wide as to threaten the integrity of the lower jaw, or who adopt the equally reprehensible habit of dragging the tongue forcibly from the mouth by means of a napkin. These are obvious obstacles to success in the treatment not only of rhinitis but of all forms of disease of the upper air-passages.

2. The spray-producers are made only for watery solutions. Vaseline is an essential agent in the treatment of rhinitis, and it must be used warm. A spray-producer with a thermometric attachment has not yet been devised.

3. The compressed air is employed under excessive pressure and is taken from a reservoir engorged with noxious germs derived from the piston of the air-pump. The latter danger may be obviated by keeping the air-pump, when not in use, immersed in an antiseptic solution. Or perhaps sufficient pressure may be obtained to squeeze the life out of these low organisms. Another reason for failure is anatomical, or error in locating the disease. The extraordinary statement is made that "rhinal inflammation invariably commences on the superior and middle turbinated processes."

4. The physiological reason.

5. The etiological reason. It is a little difficult to follow the writer in his enumeration, since he has evidently discovered more than five reasons. He very justly and forcibly inveighs against the use of powders in rhinitis. Perverted and diminished nasal secretion must clearly be a very poor solvent.

He sums up the indications for treatment as follows:

1. Diseased, acrid, and therefore irritating secretion must be removed.

2 Decomposition of newly formed secretion must be prevented.

4. Hygienic and sanative measures should be insisted upon, with a view of preventing irritation of the sensory nerves of the integument and mucous membranes. —*N. Y. Med. Record*, Nov. 23, 1889.

Sidlo on the Treatment of Ozæna with Glycerine.—One case was treated with a solution of chlorate of potash in glycerine. In addition, there were retained in the nose for an hour daily tampons of cotton soaked in one part of glycerine to three of water. After four weeks the sense of smell was restored, the offensive odor disappeared, and the formation of crusts ceased. Similar success has followed this treatment in many other cases.—*Arch. de laryngologie*, etc., Oct., 1889.

Casselberry (W. E.) on the Method of Feeding in Cases of Intubation of the Larynx by Position, Head Downward, on an Inclined Plane.—Inclined dorsal decubitus at an angle of about 20° is suitable to most cases. A little fluid will gravitate into the naso-pharynx, whence it may be removed by causing the child to swallow three or four times before the erect position is resumed. The author reports great improvement in results since he has resorted to this method of feeding, and the general elimination of one source of danger after intubation, namely, the entrance of food material into the lungs.—*Jour. Am. Med. Ass'n*, Aug. 24, 1889.

Seifert on Congenital Formation of Membranes in the Larynx.—This interesting family history is supplementary to a case of congenital membrane of the larynx reported in the *Berl. klin. Wochnschr.*, No. 10, 1888. The father had a membrane uniting the vocal cords at the anterior commissure for three or four millimetres of their extent. The mother had a normal larynx. A son, twenty-three years old, born after a former marriage of the mother, presented no abnormality. A daughter, the case previously reported, had a strong membrane uniting the cords throughout nearly their entire extent. A daughter, twelve years old, had a very slight membrane at the anterior commissure, and a daughter, seven years old, had a still less marked membrane in a similar region.—*Berl. klin. Wochnschr.*, No. 2, 1889.

Mackenzie (J. N.) on a Rare Case of Primary Lymphoid Tumor Springing from the Floor of the Right Pyriform Sinus.—The tumor was about the size and shape of the testis, and was composed of lymphoid pharynx tissue as described by Waldeyer. It was probably caused by some kind of local irritation. During the act of retching its upper surface could be seen above the edge of the epiglottis. Removal was accomplished by seizing the tumor with a pair of laryngeal forceps and surrounding the pedicle with the silver-wire loop of an écraseur. The case is believed to be unique.—*Jour. Am. Med. Ass'n*, Dec. 7, 1889.

Koch on Tracheotomy in Laryngeal Phthisis.—The following are the author's conclusions:

1. If life is endangered the operation should be done.

2. A low operation is preferable.

3. Tracheotomy is purely symptomatic, except in case of tubercular polyp of the larynx.

4. Operation being declined, absolute rest must be enforced and topical treatment resorted to.

5. If signs of laryngeal stenosis appear in a pregnant woman, tracheotomy must be done before confinement.

6. Tracheotomy practised in accordance with these indications prolongs life many years, often prevents unexpected accidents, and averts death by suffocation.—*Rev. mens. de laryngologie*, etc., Nov. 1, 1889.

Botey (Ricardo) on the Bacillus of Koch as an Element of Diagnosis in Tuberculosis of the Larynx.—The author maintains that the presence of the bacillus in laryngeal secretion may prove nothing, since it may have been derived from the lungs. Its absence does not establish the absence of tuberculosis, so that he is obliged to admit that the bacillus is an unreliable diagnostic resource in chronic laryngeal phthisis, although it may be of service in acute miliary tuberculosis. —*Rev. mens. de laryngologie*, etc., Nov. 15, 1889.

Rice (C. C.) on Some Unusual Manifestations of Tuberculosis of the Larynx.—"The unusual manifestations of tuberculosis of the larynx" mentioned in this paper are as follows:

1. In those cases where tuberculosis and syphilis co-exist, the lesions of one process mask those of the other. The syphilitic ulcerations, even when combined with a tubercular process, are frequently controlled by appropriate treatment, while the phthisical ulcers defy all efforts to heal them.

2. The typical appearances of a tuberculous larynx are sometimes greatly hidden by the proliferation of two varieties of tissue—the one being ordinary granulation tissue springing from an ulcerated surface, and the second a papillomatous growth made up of normal elements, very much resembling the ordinary papilloma of the larynx, and existing, perhaps, as a mere coincidence, but probably occasioned by the chronic inflammatory condition of the larynx.

3. Adhesive inflammation at the anterior ends of the vocal bands may occasionally take place in a tuberculous larynx, but only when such favorable conditions are present as immovable cords and a general proliferation of tissue.

4. The deposition of tubercle may be localized in one arytenoid, giving none of the typical signs, the larynx as a whole remaining perfectly normal in appearance. —*N. Y. Med. Jour.*, pp. 234, 266. 1889.

Schnitzler (J.) on the Diagnosis and Treatment of Tuberculosis of the Larynx.—The author discusses three questions: (1) the existence and treatment of catarrhal ulcers of the larynx and their relation to tubercular laryngitis; (2) the possibility of laryngoscopic diagnosis of incipient laryngeal phthisis and the importance of the small grayish tubercles of the mucous membrane as seen with the laryngoscope; (3) the value of different methods of treatment in tubercular laryngitis. Although many good laryngologists have denied the existence of catarrhal ulcers of the larynx, Schnitzler is a firm believer in their frequency. He quotes an opinion expressed by himself many years ago, which additional experience has not induced him to modify. "In acute and chronic catarrhs of the larynx one may often find at certain points, notably at the posterior part of the vocal bands and in the interarytenoid space, and especially at points exposed to compression, friction, or irritation, not only erosions, but true ulcerations, round or oval, according to their situation, and distinguished from tubercular ulcers by their more hyperæmic contour, and by their comparative superficiality, except after long duration and as a result of incessant irritation, when they may extend more deeply. Under proper care and treatment they heal without trace of cicatrix and without loss of substance. If the individual presenting such a lesion is in good health, and is free from suspicion of syphilis and of tuberculosis, one is justified in regarding the ulcer as catarrhal."

The diagnosis is more difficult when there is unusual swelling of the larynx, and in addition the patient has pulmonary tuberculosis. The discovery of the bacillus may be of service in such cases under certain precautions. The denial of the existence of catarrhal ulcerations of the larynx by such men as Eppinger, Heinze, and Virchow may be due to the fact that they are accustomed to observing ulcers of the larynx only in post-mortem examinations, and are not in the habit of using the laryngoscope. Undoubtedly a simple ulcer may undergo transformation into a tubercular ulcer, not only in tubercular subjects by infection from the lungs, but also in healthy individuals by infection from without. The details of the case of Hering, the well-known laryngologist, who was himself the subject of catarrhal ulceration of the larynx, so diagnosed by Schnitzler, but pronounced tubercular by two other high authorities, are narrated. The ulcers healed under simple treatment. Had curetting and lactic acid been resorted to this method would have received the credit of curing a tubercular ulcer.

The author attaches great importance to the miliary tubercular nodules met with in the larynx, and considers them one of the earliest indications of tuberculosis of the larynx. In speaking of the treatment of laryngeal tuberculosis the author remarks that he is aware of no case of advanced disease in which any other remedy has been followed by success equal to that attending the use of iodoform. He claims to have been among the first to recognize the curability of laryngeal phthisis. Among the means which have given him the best results he mentions, as anæsthetics, morphine and cocaine; as astringents, acetate of lead and phosphate of lime; as antiseptics, phenic acid and iodoform.

The paper closes with a strong recommendation of the local use of balsam of Peru combined with flexible collodion. The swelling of the mucous membrane subsides, secretion diminishes, superficial erosions promptly heal, deep infiltration lessens, and extensive ulcerations show a marked tendency towards repair. Its application produces an agreeable warmth, reduces pain, and alleviates dysphagia. Cicatrization and permanent cure of the

local lesion may be expected only when the general disease is not too far advanced, or undergoes temporary arrest.

In the discussion on the foregoing paper Hering and Moure coincided with Schnitzler as to the existence of simple catarrhal ulcers of the larynx. The former recognizes two varieties of catarrhal ulcer: the superficial, which heals readily leaving no trace; and the deep, which is usually seen in the interarytenoid region, and leaves after healing some thickening of the mucous membrane, called by Virchow "pachydermia." Tubercular and catarrhal ulcers often closely resemble each other. There is no doubt of the possibility of curing the former, but the cases must be selected. Curetting and lactic acid he considers by far the superior mode of treatment.—*Rev. mens. de laryngologie*, etc., Oct. 1, 1889.

Vysokovitch on Scrofulous Glands of the Neck and their Relation to Tuberculosis.—1. So-called "scrofulous" disease of the lymphatic glands is no doubt a tubercular process induced by tubercle bacilli.

2. A small number of bacteria in degenerated glands does not indicate slight pathogenic significance, since they may be very scanty even in undoubted cases of acute tuberculosis of the glands.

3. After prolonged sojourn in the glands the tubercle bacilli probably lose their virulence. Hence inoculation tests may not be satisfactory.

4. Scrofulous disease of the glands must be differentiated from lymphadenoma, lymphosarcoma, and lymphadenitis, which bear no relation to tuberculosis.—*The Jour. of Laryngol. and Rhinol.*, Dec., 1889.

REPORT ON ORTHOPÆDIC SURGERY.

BY JOHN RIDLON, M.D.

Battle (W. H.) on a Case of Excision of Both Hip-Joints for Acute Disease.—The attack came on suddenly and without assignable cause. Eight weeks later he came under observation. The temperature was then 104°, he was sweating profusely, had constant diarrhœa, had bedsores over all bony prominences, and extensive suppuration at both hip-joints; the left hip was subluxated, and at the right the epiphysis was separated. Excision was performed on both hips with an interval of three days and the general condition began to improve at once. He was under treatment four hundred days, and the result was a cure with one leg an inch shorter than the other, but with legs parallel, and with ability to get about rapidly and well without support of any kind.—*Lancet*, Oct. 12, 1889.

Collier (M.) on Trephining the Sacro-Iliac Joint in Sacro-Iliac Disease; with a Case.—The patient was a female, married, thirty-four years old. For four years she had had pain in and about the hip and lameness.

On examination, the right hip-joint was normal, and the thigh was slightly flexed on the abdomen. There was nothing abnormal to be noticed front or back—no tumor or thickening in the pelvis to be made out. The patient complained of pain on walking or sitting on the right tuber ischii, pain on coughing, pain during micturition, radiating down to the pubes of the right side and down the right thigh; pain also on deep pressure in the right iliac fossa; pain on pressing the ilia together; pain also well marked on pressing immediately over the centre of the joint behind; occasional pain down the back of the right thigh and the right knee-joint. On walking, the patient stepped cautiously, inclining the body to the right side and advancing the right leg in front of the left. The toe was not everted. From these symptoms I had little doubt that disease existed in the sacro-iliac joint.

I proceeded to open the joint with a medium-sized trephine. When on the table a distinct swelling was noticeable over the joint about as large as the palm of one's hand. Examined per vaginam and rectum the pelvis was free from disease. A curved incision, eight inches in length, parallel with, and an inch below, the posterior third of the crest of the ilium, and descending vertically over the joint, exposed the bone sufficiently. The bone was next denuded with the elevator, and now was seen to be distinctly swollen and inflamed. A line being drawn from the anterior superior spinous process to the posterior superior, two inches were measured from this posteriorly. The pin of the trephine was placed on the line, so that the edge of the circle should be on the two-inch limb. The bone appeared softer than natural, the trephine rapidly penetrating to the joint. On re-

moving the button of bone with the elevator a bed of soft fleshy granulation tissue was reached, fully one third of an inch in thickness. The opposing surfaces of the joint were quite denuded of cartilage, and the bone on the sacral aspect was eroded, hard, and of a distinct yellow abnormal color. The whole of the granulation tissue and dead bone, as far as could be reached, was removed with the gouge and mallet, the joint swabbed with chloride of zinc (forty grains to the ounce) and subsequently well dusted with iodoform. A large drainage-tube was inserted to the bottom of the opening, and the wound closed and dressed after the usual fashion. I need not weary my readers with the details of the case. Suffice it to say that all pain ceased immediately after the operation. The wound healed throughout by first intention, and at no time was a drop of pus ever present. The patient made an uninterrupted good recovery, and after a subsequent rest in the splint for six months left the home for the seaside, and has now returned to South Africa.

In conclusion, I would recommend that all cases of iliac disease where suppuration is threatening, or where pain is severe, to be treated in a like manner.—*Lancet*, Oct. 19, 1889.

Billings (Frank) on Osteo-Sarcoma of the Spine.—Three cases are reported in detail. The symptoms must necessarily be peculiar to each case. Pain in the spinal column near the seat of the tumor, with neuralgia of the corresponding spinal nerves is almost constant. The precursor of this pain is often a general back-ache, most often located in the lumbar region. Marasmus and cachexia naturally occur, as in other malignant diseases, to a degree not explicable by a less quantity of nourishment taken, or by a great loss through the natural excretory passages. The presence of sugar in the blood is not of sufficient reliability to make it a good positive sign of sarcoma in the body. Peptonuria sometimes occurs but is not distinctive. As a rule indigestion occurs, and the symptoms referable to dyspepsia may mask the principal disease.—*No. Am. Practitioner*, Nov., 1889.

Gibney (V. P.) on the Typhoid Spine.—Three cases are detailed. The symptoms were as follows: Pain in the back usually severe, some tenderness on pressure, rigidity, pain on flexion, especially lateral flexion, no psoas contraction when the affection is situated in the lumbar spinel In one case there was elevation of general temperature; in the other two there was none. In one case there was flexion of legs on thighs, and thighs on trunk.

All the cases recovered rapidly and perfectly under rest to the affected part.—*N. Y. Med. Jour.*, Nov. 30, 1889.

Goldthwait (J. E.) on Ultimate Results of Osteotomy and Osteoclasis.—The author summarizes as follows: Twenty-eight cases are reported, fifteen cases of osteoclasis, twelve of osteotomy, and one case in which both operations were performed. The average time which has elapsed since the operation is four years. Of the twenty-eight cases, twenty-seven are found in excellent position, while one, a case in which the rachitic processes were active after operation, has relapsed. The average age of operation was four years, while the youngest child was operated on at the age of two years, and the oldest was ten years of age. Double talipes valgus was found in fourteen cases, and single in two cases, and a tendency to toe-in was also a frequent occurrence.—*Boston Med. and Surg. Jour.*, Oct. 3, 1889.

Myers (T. H.) on Traumatism of the Hip, Simulating Thyroid Dislocation.—Immediately following a fall on the sidewalk, and persisting for some weeks, the patient, a child of nine years, presented flexion, abduction, and outward rotation of the thigh without any pain and with very little tenderness. Under ether the flexion and abduction disappeared. The muscular spasm returned after the etherization, but to a less degree. The following day there was a little pain, and the second day flexion, abduction, and rotation had disappeared. A long traction splint was applied and continued for four weeks, when the joint was apparently in normal condition.—*Atlanta Med. and Surg. Jour.*, Nov., 1889.

Roth (B.) on a Splint for Foot-drop.—The splint consists of a piece of tempered steel bent to fit the outline of the calf, and running from the conventional calf-band down the back of the leg to the heel of the shoe to which it is fastened by catch joint or permanently riveted.—*Lancet*, Oct. 26, 1889.

Ridlon (J.) Report of a Case of Congenital Dislocation at the Hip.—The patient was a female, ten and a half years old. The right leg was rotated out-

ward; the thigh flexed on the pelvis, and the lumbar spine lordosed. There was two and a half inches shortening. The dislocation proved to be upwards and forwards, and there was a twisting forward of the femoral neck, so that when the head was brought over the acetabulum the leg was rotated inward full 90°. Treatment by a traction splint for a year in bed and six months more walking reduced the lordosis and flexion to normal lines, and the shortening to one half inch.—*Med. Record*, Nov. 16, 1889.

Morton (T. G.) on Inequality in Length of the Lower Limbs as a Cause of Lateral Spinal Curvature.—The writer believes that he is warranted in drawing the following conclusions:

1. That inequality in the length of limbs in otherwise sound and healthy individuals is the rule, and equal length the exception.

2. That in many cases the inequality is slight and may be compensated by muscular adjustment, or by tilting the pelvis.

3. That where the difference is excessive, *i. e.*, more than an inch or so, the inequality may be made up by limping or walking upon the ball of the foot, without producing lateral deviation of the spine.

4. That a minor degree of inequality occurring in a young adult favors the development of spinal curvature.

5. That many cases of backache, sciatica, spinal irritation, etc., are due to lateral curvature arising in this manner.

6. That the cause of the deformity being recognized, the remedy consists in applying means to restore and maintain bodily symmetry.

7. That many cases of spinal curvature are promptly curable by these means.

8. That before applying a plaster jacket or mechanical appliance to a patient suffering with incipient rotary lateral curvature of the spine, we should always measure the lower limbs to see if asymmetry will explain the cause of the deformity.

9. That the recognition of natural asymmetry of the lower limbs is of great importance in medico-legal sense in estimating the results of treatment of fracture of the femur. If one limb is found to be longer than the other after recovery from a fracture, it does not prove that the limbs were previously of equal length, nor, indeed, that the difference may not have been even greater before the injury.

10. That it is not claimed that all cases of irregularity in the length of the lower limbs present symptoms, nor that all cases of lateral curvature of the spine are due to want of symmetry in the lower extremities, although this is an efficient, and often an unsuspected, cause of spinal deviation.—*Med. Times*, March 1, 1888.

Charcot's Joint-Disease.—In the *N. Y. Med. Jour.*, July 7, 1888, Dr. Parker Syms reports a case at length. In discussing the subject he says:

The symptoms are well marked. The indication of tabes cannot be many nor prominent early, as the joint-disease begins in the initial stage. The constant symptom of tabes present is analgesia, especially of the deep parts. Usually the patellar reflex is wanting, and we can add the Argyll-Robertson pupil, and more or less inability to stand or walk without the aid of sight. The various deformities of the joint which may be found need not be described.

The sudden onset, the lack of pain, and the rapid destruction of the joint are diagnostic. They certainly distinguish it from arthritis deformans, the one disease with which it is likely to be confounded. Arthritis deformans is much slower in its progress, is always the cause of pain, and some motions of the joint are always restricted, while in Charcot's disease the joint is usually abnormally movable in every direction. Of course the nervous symptoms must help the diagnosis. The patient's disability is usually very great, though in all but one of the cases I have seen they have been able to walk with a cane.

At a meeting of the Pathological Society of London (*Lancet*, January 21, 1888), Dr. Collier showed a knee-joint affected with Charcot's disease; the patient died in general paralysis, and had locomotor ataxy when seen in the Radcliffe Infirmary on August 25, 1885, when she was ataxic, and had anæsthesia without knee-jerks. The left lower limb was swollen, and also the knee-joint, where the swelling began six months before August, 1887. The joint exhibited grating and increased mobility. The patient died in December, 1887. The crucial ligaments were completely destroyed; much new growth of bone was found on the posterior surface of the head of the tibia and the internal condyle of the femur.

In the *Lancet*, March 31, 1889, Dr. C. E. Beevor showed a patient, a carpenter, aged fifty-three years, who was suffering from

locomotor ataxy, with disease of the left shoulder-joint. There was no history of syphilis. Two years ago he suffered from weakness and giddiness, with shooting pains in the legs and then in the arm; for eighteen months he had been subject to frequent flatulence and eructations; for one year he had difficulty in walking in the dark, and for the last four days had œdema of the left arm. At present he had only slight staggering with the eyes shut, and was unable to walk "toe and heel" along in a straight line, he had lightning pains in the legs, and especially in the arms, and sometimes also in the head. The pupils were small, they reacted to accommodation, but not to light, the knee-jerks were absent, and there was no anæsthesia of the legs. Eight weeks ago the patient noticed that the left shoulder began to swell, but without pain; he never had any injury to it. At present the joint was much enlarged, distended with fluid, and grating could be obtained; the head of the humerus was difficult to feel, but it did not seem to be wasted. The disease probably involved the upper part of the cord most, as shown by the lightning pains in the arms and head, the slight amount of staggering with the eyes shut, the absence of anæsthesia in the legs, and the affection of the shoulder-joint. He had no attacks of vomiting, but suffered from frequent flatulence.—Dr. W. B. Hadden asked if Dr. Beevor had examined the muscles electrically. He alluded to the fact that Charcot had found atrophy of the spinal motor-cells in some of these cases, and it was possible that in the case under consideration some atrophy of the shoulder muscles might be present.

In the *Brit. Med. Jour*, March 17, 1888. Dr. Prowde showed a knee-joint and head of femur from a case of Charcot's joint-disease. They were taken from a man aged sixty-two, who had never had syphilis, and who had no family or personal history of rheumatism or joint affection. Eight years ago symptoms of locomotor ataxy showed themselves. The knee-joint rapidly swelled, and severe pain was complained of. The joint afterward became dislocated, then the left hip-joint became affected, and this was followed by disintegration of the left elbow-joint. The joint exhibited was completely disorganized, but on its under surface some new growth of bone was discernible.

At a meeting of the Sheffield Medico-Chirurgical Society (*Lancet*, Dec. 3, 1887) Mr. Reckless introduced this patient, a man aged forty-seven. For eight or nine years he had been the subject of locomotor ataxy. For six months pain had been experienced in the shoulder. He has never had any ataxic symptoms referable to the upper extremity, but when first seen three weeks ago the movements of the left arm were limited to underhand movements. He was markedly ataxic, and was obliged to support himself with his arms whenever he rose from his seat. Patellar reflex was abolished; pupils were extremely contracted, and had the Argyll-Robertson reaction. The left shoulder looked fuller than its fellow; it was flattened under the acromion process, and the finger could be pushed well in under the process. The head of the humerus was plainly visible under the clavicle. On extending and rotating the arm, the head readily slipped into the axilla with a grating noise; it was easily replaced.

Dr. Glynn reported a case of Charcot's disease of the knee-joint (*Transactions of the Liverpool Medical Institute*, March 3, 1887), and drew attention to the fact that the man had come to the hospital complaining only of the weak knee-joint; he was not annoyed by nerve-troubles of any kind; a careful examination was necessary to detect the serious underlying condition, as the more striking symptoms of locomotor ataxy were absent; there was little or no inco-ordination, no ataxic gait, no difficulty in standing with closed eyes. The signs of ataxy were, however, sufficiently positive; the pupils were abnormally small, there was internal strabismus of the left eye, the Argyll-Robertson phenomena were marked, the knee-jerk was absent, and there was decided analgesia of the left leg and foot. The plantar reflex was exaggerated on the right side, absent on the left; the cremasteric reflex also was well marked on the right, and not obtainable on the left; the abdominal reflex was pronounced on the right, feeble on the left. No inco-ordination of the upper extremities; no bladder troubles; no history of any crises.

At the meeting of the Surgical Section of the New York Academy of Medicine (*Med. Rec.*, Nov. 26, 1887), Dr. Willy Meyer presented a patient, a man thirty years of age, who had never shown any evidence of secondary syphilis, but three

years ago symptoms of tabes began. The left knee was involved by the arthropathic disease, and showed the deformity of genu-valgum. There was history of traumatism. The tibio-tarsal joint had also become involved recently. Orthopædic treatment was in operation.

Dr. Parker Syms presented a patient, a man apparently sixty years of age, who denied syphilis and had not shown any of its secondary manifestations. Four years ago, after exposure immediately following a bath, he began to feel a weakness in his lower extremities that interfered with walking. There was no disturbance of sensation. Soon after, he had the sensation of walking upon a spongy surface. The joint-trouble appeared last summer in the left knee, where dropsy became marked, attended by swelling of the thigh. There was also considerable thickening of the capsule and the condyles. The man had unmistakable tabes. Although the eyes did not show the characteristic Argyll-Robertson pupil (loss of pupillary reflex to light), there was complete loss of tendon-reflex on both sides and inability to stand with the eyes closed. There was possible atrophy of the optic nerve of the left eye.

Dr. R. F. Weir presented a patient with a greatly distended ankle-joint. He was fifty-one years of age and without syphilitic history. There was history of articular rheumatism. Six years ago his left ankle began to swell. Prior to that he had had stabbing pains in the legs, staggering gait, inability to walk in the dark, and now has the peculiar, contracted pupil. There were osseous plates on each side of the joint. No other joint was affected.

INSANITY AND NERVOUS DISEASES.

BY FREDERICK PETERSON, M.D.

Mann (F. W.) on the Zoöscopic Hallucinations in Alcoholism.—The author, in a paper upon alcoholic hallucination read before the Detroit Medical and Library Association, brings together some very interesting facts and theories with regard to this particular variety, concerning which we quote the following from the *Physician and Surgeon*, Nov., 1889:

"The visual hallucinations of alcoholics are exceedingly varied. They may be hideous, grotesque, or awful, or they may be gorgeous, splendid, or inspiring. Unpleasant features usually predominate, and the patient is puzzled and tormented by the presence of rats, mice, beetles, worms, fleas, and other insects. This condition of zoöpsic hallucination is one of the commonest among the phenomena of alcohol poisoning.

"I do not recall having seen any explanation of the reason why animals enter so largely into the composition of the primary illusions of alcohol. These illusions a little interrogation of the patient will usually substantiate as present. A patient only the other day declared how he saw a rhinoceros, several huge elephants, and strange-looking reptiles browsing in the yard.

"A word should be said on the snake hallucination. Disorders of this kind are associated in the popular imagination with excesses in the use of alcohol. 'Seeing snakes' is in reality not a common experience. The two or three cases we have seen convince us, however, there is some basis for esteeming this one of the occasional retributions of excessive zeal in devotion to Bacchus.

"The snake hallucination is difficult to explain. Disturbances in the peripheral organs of vision seem hardly competent to account for such aggravated symptoms, although there are facts suggesting the plausibility of such an explanation. A patient in a room, where the pattern of the wall-paper or the carpet abounds in geometrical figures and circles, is apt to find these endowed with gyratory movement, and as a result may come to imagine snakes about him. But the usual causes of this hallucination seem central in origin and due to pre-existing imaginative impulse. Why should this impulse assume the snake form? May not the explanation lie in the facts of nascent consciousness? We know that stimuli cannot be co-ordinated without some ganglion through which they are brought into relation. In effecting this co-ordination the ganglion must necessarily be subject to the influences of each stimulus and must undergo a succession of changes. This action and its reaction implying perpetual experiences of resemblances and differences constitutes, according to psychologists, the raw material of consciousness. Therefore, as a corollary of this process, Herbert Spencer asserts that as 'consciousness is developed some

kind of instinct becomes nascent.' That there is a nascent instinctive dread of the serpent in man and monkey is obvious. There is every reason for it. The early history of our race abounds with record and tradition of that internecine strife between man and the serpent. We find the serpent permeating all his mythology, a chief feature of his legends, inscribed on his monuments, engraved on his symbols, and worshipped as his God.

"Even before this period the dread of the serpent may have been implanted in our human neuroplasm. Dr. A. E. Brown recently made some experiments in the Philadelphia Zoölogical Gardens, and found that monkeys, who, born and reared within the gardens, had never seen a reptile, yet exhibited great fear and curiosity when a snake was placed in their cage. An alligator or turtle caused no surprise whatever. Other animals like the ox and the hog were either perfectly indifferent, or manifested no fear of the snake."

The author's description of zoöscopic hallucinations and his theory to account for some of them were discussed at the meeting of the association, the remarks of Dr. Frank W. Brown being of especial value, as they represent the conclusions as to the origin of such hallucinations at which most students of the subject have arrived. Dr. Brown said:

"I cannot altogether agree with the Doctor as to the important part taken by nascent consciousness in the creation of these hallucinations. I do not think that nascent consciousness enters largely into the formation of the most common of all forms, primary hallucinations—that is, into those first, simple hallucinations which, if continued (and the majority of them are not), may grow to be more elaborate. Nascent consciousness does, however, have much to do with the elaboration. In the graphic descriptions of the struggles of the legal gentleman it would be interesting to know whether he conceived the snakes before the sentence of the judge, or whether they grew in his construction of that sentence; for in the former case they would be a primary hallucination and in the latter an outgrowth of elaboration. Primary hallucinations, I think, arise largely from misinterpreted perceptions—false cognition. The nerve cells, weakened by continued onslaught of alcohol, no longer possess the power of discrimination, they are content to resolve perceptions in the slightest possible way. Just as in that pathological state characterized onomatopoiesis, where the patient lapses into that simple language which names animals by their sounds, so may the weakened nerve-cells of the alcoholic be content to picture living things at the behest of a suggestive touch.

"Bugs, ants, mice, and rats are common hallucinations, but they are generally found *first* on the body and then afterwards in the room and on the furniture. The appearance first on the body can be explained on the supposition that the hallucination was created by a dermic sensation, or of formication, which would quickly lead, through imperfect cognition, to the conception of a bug or an ant, and then secondarily manifested as a visual hallucination. When seen first on walls or bed, they may be suggested by the so-called *muscæ volitantes*, not uncommon in delirium. As a refinement of this idea, could not the primary hallucination of snakes be brought about through misinterpretation of a *cutis anserina*, which sweeps coldly, wave-like, and rhythmically over a portion of the body? If this process seems complicated, it might explain the infrequency of snakes as an hallucination. Other hallucinations arising in the way I have indicated can be brought about by the red flashes, dust, retinal irritation, which often precedes active delirium, and which suggest a fire, or, more elaborated, a hell; ringing in the ears, a cataract, etc. As to the part taken by nascent consciousness in the creation of the reptiles in the snake case given by the Doctor, I might say that he has been a witness against himself, in that he has not exaggerated in his vivid description of those miserable forefathers of ours in their sometimes unsuccessful attempts to avoid their most uncanny if not most horrible enemy, and from whom we consequently derive one of our most pronounced examples of nascent consciousness If, then, nascent consciousness be a leading factor in the production of hallucinations, why do snakes so seldom appear as one of their manifestations?

"As to the suggestions given by figures on carpets or wall-paper, they create illusions, not hallucinations, as their origin deals with defective cognition influenced by the imagination, rather than with nascent consciousness."

Although various hallucinations and also delusions were discussed in the paper, no reference was made to the peculiar form of paramnesia, so characteristic of alcoholic delirium, which all must have noted who have had much experience with disorders of this character, viz.: the paramnesia which the editor has referred to in the ANALECTIC as having first been mentioned by Dreschfeld, later by C. W. Suckling, and to which Dr. M. D. Field recently devoted a paper before the New York Neurological Society. Zoöscopic hallucinations and this peculiar paramnesia are features of alcoholism that merit further study.

Peterson (Fred'k) on the Sense of Smell.—There is no other cranial nerve which presents so much to puzzle the physicist, the anatomist, and the physiologist as the olfactory. The course of its fibres, from the nasal mucosa to the cortex in the temporo-sphenoidal lobe, is devious and obscure, but the phenomenon of matter of various kinds imparting the sensation of odor by contact with the periphery of the first nerve is still more mysterious. With regard to light and color and all the sounds of the octave, we have long been able to conceive of their reception and differential appreciation by the cortex as due to vibration and variation in vibration rates. The wave theory accounts satisfactorily for these visual and auditory phenomena.

There are some well-known facts concerning the olfactory sense which have always been matters of daily familiarity, but which we have not as yet scientifically interpreted. For instance, some odors, though mingled together, can still be dissociated and recognized by the olfactory nerve-ends, whereas others, on the contrary, overwhelm one another, so that one only may be perceived, the other being completely suppressed. This antagonism has been little studied, and has been generally dismissed by the physiologist under the assumption of a chemical process occurring in the mixture. As illustrating this internecine warfare among smells, the odor of almonds conquers that of musk; certain ethereal oils destroy the unpleasantness of iodoform; orris-root is employed against bad breath; sulphuric ether overcomes Peruvian balsam; camphor makes the odors of the oils of lemon and juniper, of petroleum, of cologne, and of onion disappear; and coffee and cloves have the reputation in our drawing-rooms of being inimical to certain spirituous exhalations.

There seems, then, to be a sort of strife between odors of various kinds—a strife inexplicable upon any simply chemical theory; and it is more than probable that the vibratory hypothesis must needs be accepted to account for the sensation of smell as well as for those of light and of sound. Not long ago Professor Haycroft (*Brain*, July, 1888) made some investigations upon the olfactory sense, from which he drew the conclusion that the sense of smell as well as that of taste depended upon the rate of vibration of gaseous particles, and he found, moreover, a relation existing between the molecular weights and vibrations of bodies and the odors which they exhaled.

More recently Dr. Zwaardemaker, of Utrecht (*Fortschritte der Medicin*, Oct. 1, 1889), has been studying the same subject in a manner to throw additional light upon the difficult problem. He has constructed an instrument which he calls an olfactometer. It consists simply of a glass tube, one end of which curves upward, to be inserted into the nostril. A shorter movable cylinder, made of the odoriferous substance, fits over the straight end of this glass tube. On inhaling, no odor will be perceived so long as the outer does not project beyond the inner tube. The further we push forward the outer cylinder the larger will be the scented surface presented to the in-rushing column of air, and the stronger will be the odor perceived.

Should one desire to study the effect of mingling two odors, it is only necessary to saturate the cylinder of the olfactometer with one scented body, and another cylinder with another. By the juxtaposition of the ends of the two cylinders, the lengths being accurately determined, the air rushing in upon inhalation through the tubes must take up and mingle the two odors. Dr. Zwaardemaker found by this means that whenever one outweighed the other, he perceived the one or the other smell, but that when both were in exact equilibrium, either no odor at all was perceived, or at most a very weak and uncertain impression was made, which partook of the qualities of neither of the two substances employed.

But as some sort of union of the gaseous molecules could not be altogether excluded by this method, such as an indifferent osmotic or physical combination preventing sensory perception, it was deemed expedient

to make use of a double olfactometer in experiments of this character. The instrument consists merely of two of the olfactometers described above, one for each nostril. By the use of the double olfactometer one may easily convince himself that even in this procedure one odor will overwhelm another, rubber, for instance, causing the smells of paraffin, wax, and tolu to disappear. Even with very strong excitants there is never a mingling of sensations. Either the one or the other odor is distinguished by one or the other nostril, until, by careful equilibration of the two, no sensory effect is at all perceived. Sensibility is absolutely eliminated. Each nasal half becomes in this manner completely insensible to the odor inhaled through it, although its sensitiveness is really the same as before.

We are constrained to believe that there is something in the vibratory theory already applied to sight and hearing, to account for these remarkable facts in the domain of smell, and that is the interference of molecular waves with each other, producing in the former cases darkness and silence, and in the latter temporary anosmia.—*N. Y. Med. Jour.*, Dec. 7, 1889.

Ackroyd (W.) on Lunacy and Milk Supply.—The author, in an analysis of the monthly returns for the years 1880–1887, given in the 31st report of the Scotch commissioners, finds well-marked seasonal fluctuations in the number of admissions to lunatic asylums. Thus the average monthly number of admissions for the eight years is 1,699; and in the months of May, June, and July, the number is 628 above the average; while for the months of October, November, December, and January, the number is 462 below it. The rise and fall is gradual; the number is going up in February, March, and April, and is going down in July, August, and September. The regularity in the rise and fall is twice interrupted. Thus in the first half of the year the rise is interrupted by a fall in April, and the fall is interrupted by a rise in December. Such variations we found to be correlated with a number of other phenomena, such as atmospheric conditions, temperature, barometric pressure, reason, etc., and the writer discovers in addition a similar seasonal variation in the quality of milk. Studying the data afforded by the exact analyses given by Dr. Vieth of the Aylesbury Dairy Company of over 33,000 samples of milk in 1885, 1886, he finds that when the rate of admission to asylums is rising, the quality of milk is falling and *vice versa*. Mental aberration and weak milk are both alike indications of lowered vitality. He believes that even with the imperfect data at command for the comparison, one is justified in concluding that the tidal fluctuations in quality of milk and tendency to madness closely correspond with each other, and that it is a subject worthy of further and more precise study.—*Prov. Med. Jour.*, Dec., 2, 1889.

On Reform in the Care and Treatment of the Insane.—There is a singular fanaticism in the way in which many conscientious, but misguided people in New York State are endeavoring to have all of the insane put under State care. They do not seem to realize that there are in the neighborhood of 25,000 lunatics in this State at present, and that the number is constantly increasing. Contrasting such an aggregation of insane with the accommodations of our seven or eight State institutions(certainly not above 6,000 beds), it means that New York must construct some *twenty new State asylums* within at least the next decade! It means either that, or that unjust discrimination is to be made against certain communities, by providing superior advantages for some pauper lunatics, in some localities, while in others they are to be subjected to the same unfortunate conditions as before.

The worst of this proposed change is that New York and Brooklyn are to pay in taxes more than half of the cost of construction of all these magnificent institutions, as they have done in the past, and are yet to be excepted from the advantages to their own insane which such superior asylums would afford. It means that the chronic dement of any village in the State will have better care and treatment than the acute insane of these great cities. The former will be supported probably at the usual asylum rate of $3–5 per week, and the latter at $1.40. For instance, the per-capita weekly cost of care of incurable insane from certain counties at the Poughkeepsie asylum has always been in the neighborhood of $5. The curable insane of New York City, who should have so much better care,are treated on the islands at a per-capita daily cost of some 20 cents. Yet New York City and Brooklyn paid more than half of the expense of building this most

costly of all existing asylums in Dutchess County.

Some statistics bearing on this question will be found in a paper of mine read before the N. Y. State Medical Society, and published in the *Medical Record*, June 5, 1886.

The fact is that the reform necessary is in the construction and management of these great State asylums themselves, and they should receive for treatment the curable insane, returning them to properly provisioned county or district asylums when they are no longer amenable to superior treatment, and no longer require the highest attainable care.

Apropos of the subject I quote the following from an editorial in the *Provincial Med. Jour.*, Dec. 2, 1889:

"We have on several occasions during the past ten years written on the subject of the accommodation for the insane, and we have pointed out some of the evils of the existing system. For years we have been content with collecting together, into monster institutions, the demented, the imbecile, the epileptic, the maniacal, etc., and placing them under the superintendence of a medical man, to whom also is intrusted the domestic management of the institution necessary for the housing of the large number of lunatics in our counties. Some of our asylums have 1,000 to 1,400 patients under one medical superintendent, who is also general manager. It is true that there are assistant medical officers, but even with this assistance the medical direction is imperfect. This is one aspect of the subject. Another arises from the expensive manner in which these asylums are fitted up. Yorkshire, in its West Riding, has now three asylums: Wakefield, Wadsley, and Menston; the accommodation in each asylum being for 1,400 patients. The style in which these asylums are built, and the surroundings, are simply extravagant; and we do not wonder that they are filled, or that friends of patients should be only too anxious to place their weak-minded relations in places which promise so much. The zeal of the medical superintendents is so well known that any thing we have to say cannot detract from their merits; they are the creatures of circumstances.

"The asylum by its name condemns the system; it means that society is relieved of the presence of its lunatics, and that they are protected—finding a haven of rest and comfort, so that the curable and incurable cases find in the same establishment both treatment and protection. Some years ago the Halifax guardians, not being allowed by the Local Government Board to extend their buildings, and wanting accommodation for their ordinary sick, sent all their chronic incurable cases, to the number of 140, to Wadsley, and we believe a number of them are there still. The change was effected without loss to the guardians, as the grant of four shillings per head was received by the exchange. But this was simply turning Wadsley into a boarding-house, and crowding the establishment with a dead weight—increasing the responsibility of the medical superintendent without bringing into play the exercise of his higher capacity—viz., the application of his therapeutical knowledge to the cure of insanity. Other unions, no doubt, followed the same plan, so that we do not wonder at the rapid filling of our Yorkshire asylums. The Halifax patients were removed from very excellent wards, quite equal to the accommodation in general hospitals, but of course not to be compared in any way with the luxury of the modern asylum; so that these patients gained by the improvement in their surroundings; but they were not one bit better off as regards diet. They had gingerbread at Halifax and gingerbread at Wadsley, with this difference, that at Wadsley the gingerbread was gilded.

"We trust that some steps will be taken to reconstitute the old system; to leave the imbeciles and demented in proper care in their own parishes, or in imbecile wards in connection with union infirmaries, taking precautions that they shall be treated as well as they have been at the asylums. We in this connection welcome the attempt now being made in London to institute a hospital for the treatment of brain diseases. It is supported by practical medical men who know the imperfections of the present system, and judging by the support the proposal has received, we shall probably have a hospital of this kind opened under the protection of the London County Council. It may be considered a reproach to our present superintendents. It may be said, have we not already hospitals of this kind? We have indicated already the objections to the old system. In due time the provincial county councils will move and convert the present *asylums* into hospitals, and the superintendents will

have every reason to be content with the change."

On the Study and Curative Treatment of Insanity; a Hospital for London.—The great demand for psycopathic hospitals, where the insane may be treated, and not merely clothed, fed, and kept warm upon the lowest economical basis, is to be met in one place at least —London,—and it is time that New York was waking up to the extreme necessities of her own insane. Bloomingdale, which has received hitherto the richer classes of insane, is about to be removed to some distance from the city. The islands are inadequate in accommodation and in character of accommodation to meet the requirements of these unfortunates.

A psycopathic hospital in the heart of the city, and in the neighborhood of Central Park, say on Eighth Avenue, to receive those requiring immediate care and the highest medical skill, is the prime necessity of the hour. Let the city or some private individual subsidize or endow it. The following are the particulars with regard to the foundation of the proposed London Hospital, as given in the *Lancet*, Nov. 9, 1889:

"On Tuesday last, at the weekly meeting of the London County Council at the Guildhall (Lord Rosebery in the chair), Mr. R. Brudenell Carter, chairman of the committee appointed to inquire into, and to report to the Council upon, the advantages which might be expected from the establishment, as a complement to the existing asylum system, of a hospital with a visiting medical staff for the study and curative treatment of insanity, submitted the following report: The committee had received important *viva-voce* evidence from sixteen distinguished members of the medical profession, including not only eminent experts in insanity, and physicians chiefly engaged in the treatment of diseases of the nervous system, with which insanity is not necessarily associated, but also physicians and surgeons in more general practice. Printed questions had been sent to every medical superintendent of a public asylum in England and Wales, as well as to a few other persons of admitted authority, including the medical officer of St. Pancras Workhouse, who has had large opportunities of witnessing the operation of the present system. Sixty-five replies to these questions had been received and analyzed. The committee had arrived at the conclusion that a hospital of the kind described would be likely materially to increase the present knowledge of the nature and causes of insanity, and therefore ultimately to increase the means available for its prevention and for its cure. They were consequently prepared to make the following recommendations:

"(*a*) That an adequately equipped hospital, containing one hundred beds, for the study and curative treatment of insanity in pauper lunatics of both sexes, be established in the metropolis, and that it be under the direction and control of the Council. (*b*) That the ordinary medical staff of the hospital consist of a chief resident medical officer, who has had asylum experience, of an assistant resident medical officer, of four visiting physicians, each of whom shall hold office as physician or assistant physician in a general hospital, and of a pathologist. The members of this staff to perform such duties, and to receive such stipends or honoraria as the Council may from time to time direct. (*c*) That, in addition to the ordinary medical staff, the following honorary medical officers be appointed—namely: A surgeon, an ophthalmic surgeon, an aural surgeon, a laryngologist, and a gynæcologist. Each of these honorary officers should hold, or should have held, similar office in a general hospital, and they should all be available as consultants whenever required by the physicians, or for the performance of operations which fall within their respective departments, when such operations are decided upon."

The Committee were of opinion, however, that these recommendations could not be adequately considered by the Council apart from the grounds on which they rest, and also that an account of these grounds should be rendered accessible to the rate-payers, in explanation of the expenditure which would be required in order to carry the recommendations into effect. They therefore recommend: "That your committee be instructed to prepare a detailed report upon the question submitted to them, with a sufficient summary of the oral and written evidence which they have received; and that this report and summary be printed prior to their presentation to the Council."

This report was, after discussion, agreed to.

A Plea for More Doctors in State Asylums.—In State asylums, where the great mass of the insane are found, and where there should be the largest opportunity for studying this class of disease, what possibility for the medical staff to study the cause, pathology, or treatment of the cases under their care? Glance at the provision made in our asylums for the professional treatment of their insane patients. At the last reports to which we have access the asylum at Independence, Iowa, had 649 insane inmates and 4 medical attendants; the asylum at St. Peter, Minn., 874 inmates and 3 physicians; Stockton, Cal., 1434 inmates and 3 physicians; Topeka, Kansas, 578 (now nearly 800) inmates and 3 physicians. While a few make somewhat better provision, these are the average. A medical staff is provided that is hardly equal to the various other diseases with which the insane may be afflicted, and yet the public complains that insanity is not cured, and that a large proportion die. When we remember that the chief medical officer is usually the superintendent, with every department under his care—quartermaster and commissary, medical director and purveyor, physician, surgeon, and neurologist, sanitarian and roustabout,—and is held responsible for every dollar expended, by a management that will generally look with more leniency upon a few extra deaths and incurables than the expenditure of a few extra dollars for scientific investigation and curative effort, and that the most distinguished of scientists, burdened and distracted by such multifarious duties would find little time or opportunity for the investigation and treatment of disease, and that the burden would fall largely upon his junior assistants, who, in the Topeka asylum, would each have a constant sick-roll of 400 patients.

It is poor economy for the State to stint where it should be liberal. If the pathological conditions upon which insanity depends are removed, the State is not only relieved of the care and cost of the insane invalid, but he at once becomes a productive member of the body politic. On the other hand if through lack of skilful treatment his disease is, or becomes incurable, the State is not only deprived of his labor, but is burdened with his continued support. And what opportunity has a medical staff of three physicians, one at least of whom has a herculean work outside of his care for the diseased and crazy hundreds about him, each one of whom should be studied as a whole and, if possible, restored to health through the agency of mental and moral medicine continually applied, through properly regulated and adopted hygienic methods, and by drugs, and perchance the knife.

In the army of the United States each one thousand men, selected, after careful inspection, because of their perfect physical organism, have assigned for their care three competent physicians and surgeons. In our insane asylums about the same number of inmates, received after careful examination, because unsound and diseased, have assigned for their care virtually two physicians, and that is considered providing for the medical care of these dependent wards of the State.—*Kansas Med. Jour.*, Nov., 1889.

REPORT ON SURGERY.

BY C. A. POWERS, M.D.

Weir (R. F.) on the Treatment of Simple Pyloric Stenosis by Gastro-Enterostomy (by Abbe's Rings), Rather than by Loreta's Stretching Operation.—The patient was a man aged forty-one, whose symptoms of vomiting and emaciation had lasted nearly two years. Only once had blood been vomited, and this, with the duration of the case and the absence of a perceptible tumor even when examined under anæsthesia, together with the continuance of hydrochloric acid in tested meals, led to the conclusion that the stenosis was non-malignant, and that it was possibly due to the contraction of an ulcer.

The operator, after a careful review of all published cases of Loreta's operation, as well as of gastro-intestinal anastomosis, concluded that the latter operation held out the better chances for immediate and subsequent cure of his patient, and accordingly performed it in the usual way. Abbe's rings, held in place by six sutures, approximated the exposed loop of intestine and the anterior wall of the stomach close to the gastro-colic fold.

During the operation only the intestinal loop and the applied portion of the stomach were outside the abdominal wall.—*Med. News*, Dec. 14, 1889.

[December 23, 1889, eighteen days after the operation, the patient is up and about the hospital ward.—C. A. P.]

Bangs (L. B.) on Supra-Pubic Cystotomy.—Dr. Bangs gets his patients out of bed long before the healing process is completed, for, in his judgment, the function of the urethra is more quickly restored, and the openings in the bladder and abdomen are more quickly closed; perhaps by the pressure which the abdominal contents exert when the patient is in the upright condition. He thinks that even slight obstructions in the urethra may interfere with the healing of fistulæ, and recommends careful exploration of the canal.—*N. Y. Med. Jour.*, June 22, 1889.

Townsend (W. R.) on Acute Arthritis of Infants.—An exhaustive paper, and one of the most valuable of recent surgical contributions. The author, after a thorough analysis of seventy-one collated cases, eighteen of which occurred in his own practice, formulates the following conclusions:

1. Acute arthritis of infants occurs most frequently during the first year of life.

2. It is pyæmic in character, an osteomyelitis of infant life, and is caused by one of the forms of staphylococci, most frequently the staphylococcus albus or aureus; may follow traumatisms or the exanthemata.

3. The most frequent site of infection is the epiphysis near the joint, which in early life is frequently intracapsular.

4. The disease progresses rapidly, and nearly 50 per cent.[1] of the cases have terminated fatally, the most frequent cause of death being exhaustion.

5. A more or less complete destruction of the "joint end" of the bone, pathological dislocations, flail-like joints, and loss of length of limb, rarely anchylosis, are the most common results of the disease.

6. Disease is most frequently met with in hip, knee, and shoulder.

7. As soon as the disease is recognized the pus should be evacuated promptly, the joint properly drained, and parts dressed antiseptically.

8. The treatment of resulting deformities should be conducted on general orthopædic principles.—*Am. Jour. Med. Sci.*, Jan., 1890.

[1] Dr. Townsend modestly omitted to state that of the cases which were under his own care, and which were treated by approved and modern methods, but 22 per cent. died.—C. A. P.

Senn (N.) on the Surgical Treatment of Volvulus.—The author stands in the foremost ranks of original workers in abdominal surgery, and propositions set forth by him are entitled to receive careful thought. His conclusions regarding volvulus are as follows:

1. The predisposing causes of volvulus are either congenital or acquired, and consist in elongation of certain segments of the intestine, abnormal length of mesentery, and adhesions.

2. Irregular distribution of intestinal contents and violent peristalsis are the most important exciting causes.

3. Volvulus is most frequently met at the sigmoid flexure and the lower portion of the ileum.

4. Secondary volvulus on the proximal side of other forms of intestinal obstruction is not a rare occurrence; it is also frequently developed during an attack of peritonitis.

5. As a rule, the symptoms are more acute and intense if the volvulus is located above the ileo-cæcal region.

6. Vomiting in cases of volvulus of the sigmoid flexure is not a constant symptom.

7. The most important physical sign of volvulus is a circumscribed area of tympanites which corresponds to the location of the volvulus, but this sign is only of value before general tympanites has set it, and therefore enables the surgeon in many cases to make an early and positive diagnosis.

8. All cases of volvulus should be treated by laparotomy if reposition cannot be accomplished by rectal insufflation of hydrogen gas.

8. Reposition should not be attempted without evisceration.

10. Evacuation of intestinal contents by a free incision should be practised in every case where general distention of the intestines is present.

11. Enterectomy becomes necessary if any considerable portion of the intestinal wall has become gangrenous.

12. Irreducible volvulus should be treated by establishing intestinal anastomosis with permanent exclusion of the seat of obstruction from the active fæcal circulation.

13. Recurrence of volvulus can and should be guarded against by shortening the mesentery by folding it upon itself parallel to the long axis of the bowel and suturing the apex of the fold to the root of the mesentery.—*Med. News*, Nov. 3, 1889.

Young (Jas.) on Hæmophilia.—A child of thirteen months bled severely after the gum was incised for teeth. The bleeding was arrested with difficulty. The point, however, which is most interesting in connection with the case is the family history. The child's mother belonged to a family of "bleeders," but neither she nor her mother had at any time suffered in that way. One brother, however, died at the age of six from hemorrhage caused by one of his fingers having been caught in a door. Another brother at the age of seventeen, after the extraction of a tooth, suffered from continual bleeding for several days. Although this did not immediately cause death, yet, as a result of the exhaustion produced by the hemorrhage, he was unable to cope with an attack of acute enteritis from which he suffered soon after, and which ended fatally. Two brothers of the grandmother of the child died from bleeding which resulted from similarly trivial causes. —*Lancet*, Nov. 9, 1889.

Nussbaum on Recovery After Wounds and Operations.—Professor Nussbaum has found that a very good prognosis of the healing of surgical wounds can be obtained by examining the secretion from the surface during the first two or three days. If this be sanguinolent, prognosis is more or less bad. Care must be taken not to confound any slight afterbleeding with true sanguinolent secretion. The prognosis is only bad where the secretion from the whole surface of the wound is tinged with blood. If the secretion becomes free from blood on the fourth or fifth day, the prognosis, though not quite so satisfactory as if there had been none at all after a few hours, is still decidedly better than if it continues bloody up till the sixth or eighth day. In phthisical persons and hard drinkers there is nearly always a great tendency to a prolonged secretion of sanguinolent matter after wounds, and sometimes the tinge remains throughout the healing process, which is in these cases very tedious.—Editorial in *Lancet*, Nov. 30, 1889.

Verneuil on the Pathogenic Properties of the Microbes Found in Malignant Tumors.—This distinguished surgeon, after a careful and long-continued study of the experiments carried on by himself and others, avers his disbelief in the theory that micro-organisms are the cause of new growths. He thinks, however, that when present in tumors they may occasion a more or less intense and irregular fever, and that if allowed to come in contact with healthy tissue during an operation they may give rise to grave septic complications.—Editorial in *Med. News*, Dec. 21, 1889.

Stewart (J.) on Tetany.—The author supports the view that in all cases of tetany there is present an unstable condition of the nervous system, a condition which readily reacts to slight peripheral influences, rather than that the disease is the result of the absorption of the products of putrid decomposition. He believes that as the removal of the thyroid gland, both in man and animals, brings about a certain train of nervous symptoms, it follows that these glands have some important relations to the nutrition of the nervous system: whether this function consists in the removal from the blood of matters which would be injurious to the nervous system if allowed to circulate, it is difficult to determine. Experiments performed by Ewald, of Strassbourg, lend great probability to this view. He injected a number of dogs with the freshly expressed juice from the thyroid glands of healthy dogs, and invariably found that the animals became soporose and cataleptic.—*Am. Jour. Med. Sci.*, Dec., 1889.

MEDICINE AND PATHOLOGY.

Angina Pectoris and the True Cardiac Neuralgias.—There is a form of cardiac pain which is always of bad prognosis, because indicative of organic and generally incurable lesion. It was first correctly described by Rougnon, and nearly simultaneously by Heberden in 1768; it was afterwards called Heberden's disease, though Heberden gave it the name of *angina pectoris*, the word *angina* being indicative of the peculiar anguish accompanying the attack. Seneca, who appears to have been a sufferer from angina pectoris, speaks in one of his letters of the suddenness of its invasion, which he compares to the impetuousness of a tempest (*brevis impetus, procellæ similis*); and he adds that the predominant sensation is one of anguish as of impending death.

This kind of cardiodynia has its seat in the terminal cardiac filaments of the pneu-

mogastric nerve, and is due to ischæmia of the heart muscle. The old theory was that angina pectoris is a primary or symptomatic neurosis of the cardiac plexus. This is denied by the best recent authorities, who compare the pain to that attending gangrene from occlusion of an artery.

"Let us suppose," says Germain Sée,[1] "that the myocardium receives less than its normal quantity of blood; the terminal extremities of the vagus will receive less also. Now oligæmia of a sensory nerve manifests itself by pain. This oligæmia also accounts for the peculiar distress, the *angor*."

Huchard, in a recent work on arterio-sclerosis and the arterial cardiopathies,[2] which is the most complete by far that has appeared, sums up the numerous anatomical and other theories, and gives weighty reasons for the view, which he holds in common with others, that true angina pectoris is always dependent on lesions (sclerosis, thrombosis, atheroma, sometimes, however, spasm) of the coronary arteries, with ischæmia of the myocardium. The ordinary lesion is arterio-sclerosis, which is sometimes of toxic origin (diathetic, alcoholic, nicotinic), sometimes a senile degeneration.

There is an angina pectoris which ends almost always in sudden death; there are other kinds of cardiodynia, quite as distressing, which almost invariably terminate in recovery. The latter are functional and nervous. Huchard ranges the latter under the head of false angina pectoris (pseudo angina); they constitute the true neuralgiæ of the heart.

Huchard divides the peculiarly neuralgic forms into three classes: the neurotic, the reflex and the toxic. He formerly added a fourth, the diathetic; but he is now convinced that this, as a separate class, has no *raison d'être*.

(1) The neurotic is that painful condition of the cardiac innervation which has its origin in the state of the nervous system accompanying hysteria, neurasthenia, hypochondria, exophthalmic goitre, spinal irritation, neuro-arthritism, and (according to some authors) epilepsy.

(2) The reflex form, of peripheral or visceral origin, takes its point of departure in some distant irritation, as of the stomach, uterus, etc., which is reflected on the cardiac plexus. Huchard, under this head, gives instances of reflex pseudo angina accompanying intercostal neuralgia, painful peripheral excitation of the nerves of the extremities, neuromata, and neuralgia of the left arm.

(3) The toxic form is, perhaps, oftener caused by tobacco than by any other agent, and this (the nicotinic) is given as the typical toxic species, though cases have been referred to tea, coffee, and alcohol. There is a functional cardiodynia from tobacco-smoking, relatively benign, resulting from spasm of the coronary arteries; this Huchard calls *spasmo-nicotinic angina*. There is another kind, also due to abuse of tobacco, which is dependent on arterio-sclerosis; he calls it *sclero-nicotinic angina*.

The following table from Huchard, gives the principal distinctive features of the true and spurious anginæ:

TRUE, ARTERIAL, ANGINA PECTORIS.

Anatomical Cause.—Aortitis, with obliteration of the coronary arteries. Sclerosis, with constriction or obliteration of the coronaries. An arterial affection.

Symptoms.—Pains almost always paroxysmal, not permanent, provoked by walking, emotional excitement, effort. Rarely periodical and nocturnal attacks. Cardiac pain isolated from other neurotic symptoms. Agonizing pain, with sensation of compression as of a vise. Pains of short duration, ceasing with repose. Substernal seat of the pain, generally over the aorta.

Attitude of the Patient.—Silence, arrest of all movements, the pain ceasing with absolute rest. No painful points, but the latter may be present when true angina is complicated with cardiac and phrenic neuritis by propagation of the peri-arteritis to the plexuses of nerves in the vicinity. Often substernal anguish without pain.

Prognosis.—True angina pectoris is almost always fatal.

Treatment.—Arterial medication. Revulsives of no account.

FALSE, NEURALGIC ANGINA

Anatomical Causes.—Aortitis, with neuritis of the cardiac plexus. Hyperæmia of the cardiac plexus. Neuralgia of the cardiac plexus. A neuralgic or neuritic affection. Often (as in hysteria) a vaso-motor neurosis.

[1] G. Sée: "Maladies du Cœur," 2d ed., 1883, p. 30.

[2] Huchard: "Maladies du Cœur et des Vaisseaux," etc. Paris, 1889.

Symptoms.—Pains less frankly paroxysmal, often periodical, coming on at the same hour (hysterical, neurasthenic, pseudo angina); not provoked by effort, but often caused by cold. Attacks frequently periodical, recurring at fixed hours, and nocturnal. Cardiac pain associated with other neurotic symptoms. Pain less agonizing, with sensation of distention of the heart. Pains of long duration, not ceasing by repose. Seat of the pain often frankly cardiac.

Attitude of the Patient.—Incessant agitation. Continuance of walking; rest brings no diminution of the pain. Existence of points painful to pressure, especially along the track of the phrenic nerves (neuritis of the cardiac plexus and of the diaphragmatic nerve). Anguish less pronounced, always associated with the pain. Pseudo angina is never fatal, except in cases where the cardiac neuritis is associated with coronary sclerosis.

Treatment. — Anti-neuralgic remedies. Revulsives often beneficial.

REFLEX, NEURALGIC, PSEUDO ANGINA PECTORIS.

A nervous affection.

Symptoms. — Attacks spontaneous at times, but often provoked by movements of the left arm, and by pressure over the painful nerves. Depends on some other peripheral neuralgia, on gastric or other visceral disorder. Is observed at all ages. Attacks last long; are not provoked by effort. The primary neuralgic, or the visceral affection, makes itself conspicuous. Pain generally precordial, not substernal. In gastric pseudo angina, signs of dilatation of the stomach often accompanying. Prognosis benign, never terminates in death.

Treatment.—Revulsives, calmatives, anti-neuralgic remedies, anti-dyspeptic remedies.

TOXIC, PSEUDO ANGINA, FROM TOBACCO.

(Generally by Spasm of the Coronaries.)

Symptoms.—Attacks of cardiac angor associated with other phenomena of a toxic kind; vertigo, gastric and respiratory troubles, etc. Accompanying heart-troubles; palpitations, intermittences, arythmia, lepothymia, etc. Attacks last long; are generally spontaneous, rarely provoked.

Prognosis.—Rapid recovery, on suppression of the toxic cause.

Huchard gives an exemplification of the difficulty under which the clinical observer must sometimes labor in diagnosticating the affection. "In gout he may have thoracic angor under three conditions: (*a*) it is either a true angina, arising from an arterial lesion (arterio-sclerosis, theroma of the coronary arteries, lesions of the aorta, etc.) to which gouty persons are always predisposed; or (*b*) gastric troubles, frequent in gouty patients, may provoke attacks of false angina pectoris which may terminate in recovery; or (*c*) the angina pectoris may be a neuralgic attack, such as gouty neurasthenic invalids are prone to."

In true angina pectoris, the leading indication is to remedy the cardiac ischæmia which causes the pain. This indication can be only partially met by the so-called vaso-motor dilators,—nitrite of amyl (two or three drops to be inhaled from the open palm); nitro-glycerine (frequent drop doses of the centesimal dilution); and iodide of sodium, which, according to Huchard, should be given in ten-grain doses three or four times a day for a long time. Hypodermic morphia seems to favor the capillary circulation, as well as allay nervous irritation, and will be often demanded in severe paroxysms. In the pseudo forms, the general anti-neuralgic and revulsive treatment will be called for, due attention being given to the cause, whether peripheral, visceral, or toxic.—Editorial in *Boston Med. and Surg. Jour.*, Dec. 12, 1889.

Association of Heart Disease with Diseases of the Pelvic Viscera in Women. — At a recent meeting of the Royal Medical and Chirurgical Society Mr. Arthur E. Nevins read a paper on the "Frequent Association of Heart Disease, especially Mitral Stenosis, with Diseases of the Pelvic Viscera in Women." In this paper the author called attention to: 1. The frequency of the association between heart disease and lesions of the pelvic viscera in women. 2. The great predominance of mitral stenosis over all other cardiac lesions in such cases, and the fact that the symptoms were easily overlooked unless a thorough and careful examination of the circulatory system was undertaken, the patients generally suffering from pelvic troubles for some considerable time before any symptoms obviously referable to the cardiac lesion developed. 3. An attempt to classify the lesions of the pelvic viscera in relation to the frequency of their coinci-

dence with heart disease. 4. The diagnostic importance in many cases of disease of the pelvic viscera, of a knowledge of the

Table of Diseases of the Pelvic Viscera Noted among 419 Patients, Arranged according to the Frequency with which Co-existent Heart Disease was Discovered.

Disease.	No. of cases.	Cases of			Heart disease.	
		Pure mitral stenosis.	Pure mitral regurgitation.	Mitral stenosis and regurgitation combined.	Totals.	Percentages.
Granular erosion of cervix uteri	33	12	3	3	18	55
Prolapsed ovaries	7	3	0	0	3	43
Hemorrhage	31	6	5	2	13	42
Versions	58	16	4	2	22	38
Laceration of cervix	46	10	6	1	17	37
Inflammation of uterus	71	21	2	1	24	34
Pelvic cellulitis and peritonitis	52	11	3	1	15	29
Cysts of broad ligament	11	3	0	0	3	27
Conical cervix and stenosis	26	5	0	1	6	23
Disease of uterine appendages	10	1	0	1	2	20
Prolapse of uterus	19	0	2	1	3	16
Fibroids of uterus	39	4	0	0	4	10
Caruncles, vaginal and urethral	54	5	0	0	5	9
Malignant disease of uterus	24	1	1	0	2	8
Uterine polypi	18	0	0	1	1	6
Ovarian cysts	29	1	0	0	1	3
Debility	14	12	1	1	14	

soundness, or otherwise, of the heart. The observations recorded refer to 552 consecutive cases admitted into the Hospital for Diseases of Women, Soho Square. Out of these cases 133 had been omitted as having no bearing on the subject in hand, some of them being cases of cancer of the breast, others of renal disease, and so on. Among the 419 remaining cases, 111 patients (=26 per cent.) were found to have symptoms of organic disease of the heart, and, with only one exception, it was always the mitral orifice and valve that was affected. Of these 111 cases, 93 (=84 per cent.) were suffering from mitral stenosis, 29 (=26 per cent.) from mitral regurgitation, and of these 11 (=10 per cent.) from mitral stenosis and regurgitation combined. In the above table all the patients comprised in the series were classified according to the diseases from which they were suffering; the sequence of these groups of cases depended upon the percentage of heart-disease discovered in each. In this table the same patient is often enumerated more than once, as, for instance, a patient suffering from chronic enlargement and inflammation of the womb, and also from granular erosion of the cervix, would appear under both these headings; the aggregate numbers, therefore, will be found to considerably exceed the total given above. In the discussion which followed, Dr. Barnes said that the paper was an illustration of the solidarity of the functions of the body, and of the absurdity of endeavoring to consider one organ apart from the rest. Referring to the cases mentioned by the author of the paper, he said it was often impossible to make out whether the pelvic or the cardiac disease were the primary, but he was inclined to think that in many cases he had seen the pelvic affection precede that of the heart. Dr. Powell observed that in cases of mitral disease one was accustomed to meet with congestion of various organs, and menorrhagia was a common symptom. Of the large number of cases quoted, many probably had nothing to do with the mitral stenosis, but some might be attributed to the disordered circulation, such as granular erosion of the cervix, menorrhagia, and a certain proportion of the inflammatory affections. Of the total number of congestive uterine lesions referred to in the paper, nearly two out of three of them were found to be associated with heart lesion. Dr. William Duncan said that in many of the cases the occurrence of heart lesion could only have been mere coincidence; he did not believe that erosion of the cervix could be caused by mitral stenosis any more than laceration could, though he admitted that heart disease in women predisposed to hemorrhage. He related an interesting case in which he had come to the conclusion that a diseased condition of the uterus had been brought about by serious aortic regurgitant disease. He was prepared to admit that in some cases of menorrhagia and inflammatory uterine affection the heart played an important part. Dr. Routh said that it was important to note that the existence of a cardiac complication rendered these cases very difficult to cure, and that explained why gynæcologists found it necessary to keep some of their patients so long under treatment. Congestion was inevitable in some cases of heart disease, and a French observer had pointed out that whenever there was erosion of the cervix, the same condition obtained in the back of the pharynx. Dr. Hermann referred to the difficulty in diagnosing mitral stenosis with certainty; he

regarded it as a rare affection. He suggested that in studying the question of the association between diseases of the heart and those of other parts, the subject should be approached on a broader basis. First, there should be found among women suffering from pelvic disorders what proportion of heart disease existed, and then in patients with cardiac mischief it should be ascertained what proportion of them suffered from pelvic complaints. He had observed in the majority of cases presenting venous congestion from any cause, that there was a diminution of the quantity and frequency of the menses; menorrhagia was present only in a few. Dr. Frederick Taylor said that the diagnosis of mitral stenosis was extremely open to fallacy, and looking at the list of symptoms which had been detailed he failed to see on what grounds the evidence of stenosis rested. The lesion, however, was much commoner than Dr. Herman seemed to believe. He wondered whether if one took a number of cases of mitral stenosis the proportion of patients suffering from pelvic trouble would be greater than in patients with any other disease. Dr. Seymour Taylor said he had been for some years studying the subject of the connection between visceral disease and gross lesions of the heart. He mentioned a case in which a large prostate was associated with palpitation, and yet no post-mortem sign of cardiac disease was found. Malignant disease of the uterus was often associated with gross lesions of the cardiac valves. He related an instance of violent cardiac palpitation which occurred in a woman who was the subject of ovarian tumor. It subsided after ovariotomy, and many years after was ascertained not to have returned. In another case violent palpitation was associated with floating kidney. He felt quite sure that there was some connection between valvular and functional disease of the heart and disease of the viscera. He thought that with improved instruments of diagnosis the recognition of mitral stenosis was not so difficult now as it formerly was. Mr. Nevins, in reply, said that he had given his grounds for the diagnosis of mitral stenosis, but his main point was to emphasize the fact that these cases of uterine disease were associated with a certain group of cardiac symptoms; he had mentioned the symptoms which had occurred most frequently, and he left others to draw their own inferences as to their signification. He, however, had carefully read Dr. Acland's paper on mitral stenosis, and the symptoms described there so exactly tallied with those he himself noticed that he felt justified in making a definite statement as to the cardiac condition. He thought there were evidences that the cardiac disease in many of the cases preceded the pelvic disorder. He did not wish to advance the view that in all these cases the heart disease caused the pelvic lesion, but he wanted to show that certain groups of these cases had a larger proportion of heart lesion than others. He pointed out the difficulty of deciding between early malignant disease and simple congestive inflammation, and said that in these cases it was a great assistance to know whether any heart lesion was present.—*Lancet*, Dec. 14, 1889.

Engelmann (G. J.) on Menstruation and Pregnancy after Removal of Both Ovaries.—The following are the conclusions drawn from the history and microscopical examination of Dr. Engelmann's cases, which are corroborated by numerous cases of oöphorectomy and double ovariotomy now observed, whose histories have been recorded for a sufficient length of time after the operation.

1. That the continuance of menstruation after the removal of both ovaries is due to remnants of ovarian stroma left *in situ*.

2. That portions of the ovarian tissue, however small, which remain after the removal of the greater portion of the organ, whether or not the Fallopian tube be preserved, may retain their activity and continue the functions of the entire organ.

3. Even elongated pedicles may contain ovarian stroma in which the functional activity of the organ may be continued.

4. That remnants of ovarian stroma do not necessarily preserve their vitality and functional activity.

The deductions of practical value to the operator are even of greater importance, and they are these:

(*a*) For the successful performance of oöphorectomy, it is requisite that every particle of ovarian stroma shall be removed if the desired result is to be expected with certainty.

(*b*) If shrinkage of fibres, the limitation of hemorrhage, or cessation of annoying symptoms is to be accomplished with the greatest certianty, both ovaries must be

completely removed, and not even a particle of ovarian tissue left *in situ*.

(*c*) In the performance of double oöphorectomy in women not yet beyond the climacteric, and not suffering from utero-ovarian reflexes, such healthy ovarian tissue as may exist should be spared, in order that functional activity may not be impaired.—*Times and Register*, Dec. 7, 1889.

Brower (D. R.) on Paralysis of the Trifacial Nerve, Involving the Inferior and Superior Maxillary Branches.—The writer at a recent clinic showed a patient who complained of loss of sensation in the right half of the face, with the exception of a small part around the angle of the jaw. There were no evidences of tactile or of pain sense. On moving the jaw as in mastication the muscles concerned on the right side of the face did not move to the extent that they did on the left side. It seemed to be, then, a case of paralysis of the inferior and superior maxillary and ophthalmic branches of the trifacial nerve, involving the sensory and the motor functions.

He does not recognize the smell of vinegar. This impairment of the sense of smell results not from the trifacial nerve being a nerve of smell, but from the fact that it is the nerve which presides over the nutrition of the nasal mucous membrane, and by examining this membrane it will be found that it is very dry. Its nutrition is impaired because of the paralysis of the trifacial nerve.

In order to test his sense of taste *bitters*, *sweets*, and *sours* were employed, with the result of finding that, on the right side of the tongue, there is no recognition of any of them. On the right side there is no appreciation of the galvanic current, but on the left there is.

There is no conjunctivitis, no disease of the skin, nor any impairment of its nutrition. This, then, is a case of paralysis of the trifacial nerve, with the unusual features of involvement of both the sensory and motor functions of the nerve in all three of the branches.

As all the functions of the fifth nerve are involved in this case, the seat of the disease must be either at the Gasserian ganglion, at the base of the brain, or at the centres within the medulla. The former location is more probable, as the whole right fifth nerve and no other nerve is involved.

The probability is that the lesion is syphilitic, and that it is either a disease of the bone or of the membrane. The affection was gradual in its development. It is probable, therefore, that it is a tumor which, by gradual growth, has encroached upon the nerve, making pressure, first upon the inferior division, then upon the middle, and finally upon the ophthalmic branch. An inflammatory disturbance might produce the same results, but it would be more apt to involve the entire structure of the ganglion at once. It would not be so gradual in its development as he says this was. Large doses of the iodide of potassium are indicated, the paralyzed side being treated by galvanism, stimulating by means of this current the nerve, the negative pole being placed at the back of the neck and the positive over the three several branches. The skin of the paralyzed side should be stimulated by the application of the faradic brush or a dry sponge electrode. Tonics —iron, quinine, and strychnine are indicated.—*Med. News*, Dec. 21, 1889.

Pinnock (R. D.) on a Case of Closure of the Jaws from Spastic Irritation of the Masseter due to Irritation of an Uncut Wisdom-Tooth.—John McI., aged twenty-seven, married, saw-miller, consulted me on the 19th of August with this history:

Relatives all healthy; never suffered from any disease himself, except a mild attack of jaundice four years ago. Was in good general health until five weeks ago, when he began to suffer from intermittent pain in the region of the left masseter muscle. For this he tried various external remedies, without avail, and continued to do so for four weeks, when he noticed that the gum was swelling behind the last tooth of the lower jaw on the left side. This swelling became exceedingly painful, and on the following day he found that he could not separate the jaws more than a quarter of an inch. He continued rubbing pain-killer on the cheek, and applying hop poultices without effect for four days, during which period he lived on liquids administered in a spoon. On the fifth day of the closure he came in for advice.

I found it impossible to separate the jaws more than a quarter of an inch, and the attempt to do so gave him great pain. By means of reflected light from the frontal mirror, and keeping the tongue out of the way with a catch forceps, I was able to ex-

amine the cavity of the mouth, and saw a minute portion of the outer edge of the crown of the wisdom tooth projecting from the gum at the left side of the lower jaw. The wisdom-tooth on the opposite side was fully erupted. As there appeared to be insufficient space between the second molar and the ramus of the jaw for the eruption of a tooth of corresponding dimensions to the opposite molar, and having in view the history given above, and the absence of any other discoverable cause for the closure, I took him on the following morning to a dentist and requested him to try and remove the wisdom-tooth, and if he found that impossible, to take out the adjoining molar. Chloroform was given, and even when thoroughly anæsthetized we could not separate the teeth more than three fifths of an inch. Finding it impossible to remove the wisdom-tooth even after freely dividing the gum over it, Mr. McBurney with great difficulty succeeded in removing the adjoining molar. The patient had to be kept fully under the chloroform, as the jaw began to close directly its administration was interrupted. The effect of the removal of this tooth was very marked, the patient on coming to his senses being able to separate the teeth to the extent of an inch without assistance and without pain. On the following day he was able to open his mouth to its fullest extent, and all the pain which he had been suffering for so many weeks had gone. He returned to his home a few days afterwards, and has had no relapse.

From the crown of the tooth extracted to the apex of the fangs it measured $1\frac{1}{16}$ inches.

The expansion of the fangs in the line of the jaw (from before backwards) was three fifths of an inch.

The angle of the distal fang was thirty degrees.

The mesial fang was bifurcated.

Mr. McBurney tells me that he has never met with such a degree of expansion in the fangs of a tooth as the above, and that the irritation of an uncut wisdom-tooth in the presence of such crowding must have been very great.—*Australasian Medical Gaz.*, Nov., 1889.

Ulcus Rotundum, Cancer, and Progressive Anæmia.—Dr. Rosenheim addressed the Verein f. innere Medizin at its last meeting on this subject. A woman, aged thirty-eight, who had had rheumatic fever, began in October, 1887, with pains in the left side below the heart, and was confined to bed; vomiting and emaciation followed, and considerable diminution in the red blood corpuscles, with increase of the white. Up to June, 1888, free hydrochloric acid was present in the stomach, then the symptoms of progressive anæmia came to the front, and the patient died in November of the same year. The autopsy revealed a rounded opening the size of a five-mark piece, with swollen edges on the lesser curvature, which led to a cavity the size of a small apple, and filled with a necrotic mass. The new growth was attached to the pancreas, and was carcinomatous. A second case was one of a lady, aged forty-two, who had suffered for years from gastralgia, and for about a year had presented the typical symptoms of cancer of the pylorus. When digestion was most active free hydrochloric acid, hyperacidity, and hypersecretion were present. The autopsy revealed a sunken cicatrix 10 ctm., resulting from an ulcer, by which the wall of the pylorus was thickened to 18 ctm. This thickening was produced by a carcinomatous new growth. The third case was that of a woman, aged thirty-eight, who had suffered from hæmatemesis three years before, and for two years presented the typical symptoms of cancer of the stomach. The fourth case was that of a woman, aged sixty-four, who had emphysema and myocarditis. Three weeks before her death vomiting took place, and tarry stools were passed. The autopsy brought to light an ulcer 10 ctm. in diameter, from out of which a medullary cancer had grown and partially destroyed the wall of the ulcer. The part that remained determined the diagnosis of ulcer and carcinoma. The speaker had found this complication four times in fifty cases of cancer of the stomach. From this, in eight per cent. of cases of cancer of the stomach, an ulcus rotundum was the exciting cause.—*Med. Press*, Dec. 11, 1889.

Neutralization of the Bacillus Tetani.—In June last Professor Sormani, of Milan, announced to the Lombard Institute of Sciences the results of his experiments on the neutralization of the tetanigenous microbe—results which seemed to justify his conclusion that iodoform, iodol, and corrosive sublimate are absolutely destructive of the bacillus in question. To these disinfecting agents he has, as the

result of further experiments, added three more—namely, chloroform, chloral, hydrate, and camphorated chloral, the latter being, he alleges, in a marked degree efficacious; while camphor and camphorated alcohol he found inert. On a general review of the whole, however, he gives the preference to iodoform. Seven rabbits were inoculated with materials charged with the tetanigenous virus. From six of these, after an interval of twelve hours, the foreign body was removed during the period of incubation; from the seventh the substance was removed only when the first symptoms of local tetanic convulsions had declared themselves. In all these animals the wound was scraped and thereafter freely medicated with iodoform. The seventh rabbit died of tetanus. Of the first six, five were saved. From this Dr. Sormani concludes that medication of wounds with iodoform ought to be practised before the setting in of the first tetanic symptoms. Nevertheless, even during declared tetanus, the application of iodoform to the wound is capable of disinfecting it and removing from it all trace of virulence. Wounds and sores treated with iodoform, especially wounds or sores contaminated with earth, yield results highly welcome to the surgeon—such medication preventing the access of that fatal tetanic symptom which, having once declared itself, leaves but little chance for skilled interference. Dr. Sormani gave confirmatory proof of his thesis by cases of tetanus in hospital, where iodoform opportunely applied saved the patients, and where, from its use having been unfortunately suspended, two lives were sacrificed. —*Lancet*, Dec. 14, 1889.

Laryngeal Phthisis from Cohabitation.—The close observation of a large number of cases of laryngeal phthisis in married persons shows most conclusively that, in a certain proportion of the cases, the disease is communicated during cohabitation, occurring in the other of the married couple, either when the first to be attacked has arrived at a late stage of the disease, or even long after his or her death. In several instances a year had elapsed before the survivor manifested the disease. Dr. Cadier has remarked that in this primary acquired form of laryngeal phthisis the lesions are not situated—as is the case with the more common secondary variety—on the vocal cords, but are localized in the upper part of the larynx, with comparatively little tendency to spread. This special localization enables local treatment to be more efficiently carried out by means of cauterization and sprays. The author insists upon the importance of insisting on the parties occupying separate beds, if not indeed separate rooms, so soon as the disease has been diagnosed in one of them. The treatment which has yielded the best results in his hands is the application twice a week of a 1 in 20 or 1 in 10 solution of creasote in liquid vaseline, with which he associates daily spraying with chloride of zinc, morphine, cocaine, or the bromides. —*Med. Press.*, Dec. 11, 1889.

THERAPEUTICS AND TOXICOLOGY.

Hare (H. A.) and Martin (E.) on the Value of the Electrical Methods Employed for the Resuscitation of Persons who have Ceased Breathing.—In patients under ether, the movement of the diaphragm is an exceedingly interesting study, for before the condition known as surgical anæsthesia is developed, while there is still some rigidity, and the throat reflex is not completely abolished, the contractions of the diaphragm are frequently so violent that unless the laryngeal opening be absolutely free, the intercostal spaces are depressed and the abdominal contents thrust violently downward and outward. Just so soon, however, as the chin is pulled forward and a free access of air is allowed, the abdominal displacement is not so great, though it still remains present, and the chest movement is no longer reversed. As the ether is pushed, the respirations become purely thoracic, the diaphragm no longer taking part in the respiratory cycle, or becoming so relaxed that it allows the chest on expansion to aspirate the abdominal viscera upwards, as is shown by the retraction of the belly walls at a time when they should normally expand with the thorax in inspiration. This observation would seem to point to the fact that the primary stimulant action of ether upon the respiratory apparatus is particularly felt by those centres which govern the movements of the diaphragm, and that, as this is the case, these centres later on are the first to feel the paralyzing effect of still larger amounts of the drug.

This gives us, therefore, yet another danger signal during the administration of the ether, and we hold that the integrity of the diaphragmatic function, as represented by the movements of the belly walls, should be as carefully observed as are the thoracic excursions, the character of the pulse, or the condition of the pupil. The rule may therefore be laid down that when the diaphragm ceases to act, anæsthesia has been carried to its extreme legitimate limit, and that the use of an anæsthetic after this time must be carried on with the greatest care and watchfulness.

We have made other observations which tend to confirm the belief that the diaphragm is the first to yield to respiratory paralysis. In death from any cause, the progress of failure of respiration will, in the vast majority of cases, be denoted by a failure on the part of the diaphragm primarily with compensatory excursions of the chest; and it is also to be noted that as the chest movements fail, the accessory muscles of the neck come into play. These muscles in time cease to act, the hyoidean group lose their *point d'appui*, the chest remains motionless, the lower jaw is dropped, and the scene is closed by a few gasps.

In our experiments made upon animals with coal gas [1] it was found that this order of muscular involvement was adhered to, and that as the animal returned from death's door, a reversal in the order of return of functional activity was apparent, the neck muscles acting first, the chest muscles next, and the diaphragm last. Whenever this sequence is disturbed the changes are probably produced by some reflexes which escape attention, and which exert a stimulating effect, particularly upon the diaphragmatic apparatus. Thus, it has been shown that when the communicating fibres from the higher centres to the respiratory centre are cut, so as to set aside any cerebral influence, inspirations may be excited by peripheral stimulations, such as pinching the skin, douching with cold water, or the application of electricity, and that under these circumstances the diaphragm responds more readily than do the other respiratory muscles.

Not only have we found this to be true, but Marckwald has also made a similar observation. In dogs we have found that after respirations had ceased from profound etherization, and where the ordinary methods of resuscitation were unavailing, a rapid exposure of the anterior crural nerve and stimulation of the same by a strong interrupted current would cause full diaphragmatic movements, soon supplemented by thoracic excursions, after which the animal would continue breathing without any external aid.

By far the most important practical point to be gained from all this information is in regard to the methods commonly used in the application of electricity to persons who have ceased breathing, particularly during the action of an anæsthetic. While few text-books give any specific directions concerning the practical application of such methods, those that do so force the physician to a method at once dangerous and impractical, for the directions usually given are to place the positive pole on the phrenic nerve as it crosses the anterior scalene muscle at the root of the neck, the negative pole being pressed against the lower margin of the ribs, and a rapidly interrupted current being used with the purpose of causing contraction of the diaphragm by the direct action of the electricity upon the nerve. Even theoretically this is a possible source of danger, and practically we have proved danger to be an ever-present fact under its use. The cardiac inhibitory nerves run so closely to the phrenic fibres, and respond so readily to electrical stimulation, that it is hard to imagine how they can escape stimulation if a current be used of sufficient strength to excite the phrenic nerves near by. By practical experiment we have proved that inhibition of the heart may not only be possibly brought about by this method, but that it is nearly impossible to avoid its production if the phrenics are to be reached at all.

A dog, having had its neck cleanly shaved so as to avoid diffusion of the electrical current, was tied down and anæsthetized, the carotid artery being attached to the manometer in order to determine whether any circulatory change took place. In order to prevent any change in arterial pressure, the result of pain, the animal was kept well under the influence of ether. Two gravity batteries were then connected with a Dubois-Reymond coil, pushed up to 10. The sponge of the negative electrode, well soaked in salt solution, was

[1] *University Medical Magazine*, September, 1889.

applied to the lower border of the ribs in the axillary line, and a single point of wire was prepared as the positive electrode in order that the current might be more readily concentrated upon a given spot. An opening was now made in the middle line of the belly, and the fingers of the left hand thrust in till the vault of the diaphragm could be distinctly felt and its movement noted. On pressing the positive pole into the phrenic region at the root of the neck, forcible unilateral diaphragmatic contractions were excited, together with violent movements of the foreleg on that side, and it was found that to affect the diaphragm the electrode must be placed on exactly the right spot and pressed in the right direction. The violent contractions produced in the other muscles made it impossible to tell except by direct palpation whether or not the diaphragm was acting.

The action under these circumstances on the heart was most striking, for it was found that the only place where the positive pole could be put to contract the diaphragm also *inhibited the heart.*

If a current, by no means as strong as that frequently used in cases of suspended animation, produces such a profound effect upon the heart of a moderately anæsthetized dog, its effect upon a heart already overburdened by congestion or depression would be most disastrous.

Against the reflex excitation of respiration there cannot be the same objection. The electric brush produces a more powerful effect upon the terminal extremities of the sensory nerves than any known method of stimulation. Far more powerful than the douche and than abdominal applications of ether, as recommended by Hare, it should be used under all circumstances when death threatens from respiratory failure. It should not, however, be applied to the neck, but a sponge electrode being placed at the base of the ribs the brush should be applied at intervals to the epigastrium, to be removed when inspirations result, and reapplied when breathing movements cease. If artificial respiration is being carried on by Sylvester's or other of the recognized mechanical methods, the wire brush should be applied during the inspiratory movements.

It would seem probable that in those cases where the use of electricity has been resorted to, the return to life has been the result of reflex stimulation rather than a direct effect on the phrenic nerves. On the contrary, the striking effect upon the heart suggests the thought that the improper application of electricity may, in the past, have been an important factor in determining a fatal issue.—*University Med. Mag.*, Nov., 1889.

Hageman (S. A.) on Sulphonal in Reflex Muscular Spasm.—K. H., a boy about eleven years old, suffered a fracture of tibia March, 23, 1889. I saw him shortly after the accident. Being delicate and very nervous, he seemed almost frantic from pain and excitement. After adjusting the fracture and applying a bandage it was suggested by his mother that I give him "something to make him sleep." The suggestion seemed wise, and I ordered sulphonal, grains 30, to be made into two powders, directing that one be given at once (about 6 P.M.), and saying that we might need the other the next night. I thought this the more necessary, as I knew the patient to have been suffering persistently with chorea.

The powder was duly administered by the mother, and after waiting a short time and not observing any effect, she gave the other powder, making 30 grains. After waiting a little longer the mother sent to the druggist and had the prescription filled again; the two additional powders were administered without much time being wasted, and not satisfied with what she had done she sent again to the druggist and procured more; one was given and the other spilled, making 75 grains in all in the course of an hour or two.

Upon calling early in the morning (8 A.M.) I was told that he had been very restless, but had finally fallen asleep, and the facts about the powders were told me as above. I expressed my astonishment and anxiety, and turned to the patient. I was reassured by his tranquil expression and perfectly normal pulse and respiration, but the way he was sleeping was a credit to Morpheus.

I could not rouse him, and so I dressed the limb anew and went away. I saw him at intervals during the day, his condition remaining the same. I did not give any medicines, for there seemed to be no indications therefor—profound slumber, natural and tranquil.

About 6 P.M. I had him raised up and a spoonful of water put in his mouth. It

simply ran out, without any effort at swallowing.

The next morning he did swallow a little milk, and in the evening uttered the word "mamma," and so gradually came around after a continuous sleep of about four days, recovering every faculty, and without any evil effects whatever that I could observe.

I have only one comment to make; I should not recommend sulphonal for suicidal purposes.—*New Eng. Med. Mo.*, Dec., 1889.

Anderson (W.) on Fatal Poisoning by Chlorate of Potash.—In view of the widespread domestic use of chlorate of potash, and from the fact that fatal cases of poisoning by it are somewhat rare, I consider it useful to report the following case, the first one I have met in nearly twenty years' practice.

Mrs. M——, aged about seventy, in fair health, but suffering from constipation, dissolved nearly one ounce of chlorate of potash in water, and drank it all, thinking it was Rochelle salts. No special disturbance was felt at the time, but the mistake being discovered about an hour after, some mustard and oil were taken, to produce vomiting, which was accomplished. Two hours after the drug had been swallowed I was called in, and found the old lady quite comfortable, suffering no pain or distress of any kind. Being misinformed as to the quantity of the drug used, and believing it to be probably about two drachms, I gave a favorable opinion, prescribed a dose of castor-oil, to be followed by a solution of bismuth. Four hours after I was again called, and found the patient in a state of collapse. While defecating, she had fainted. The lips were blue, the tongue of a purplish color, and the face ashen. On rallying a little, she declared she had no pain, but immediately commenced to vomit a profusion of mucus. There was no sign of blood in the discharge. The temperature was 100° F., and the pulse about 100—weak, but not irregular. No oppression of breathing; feet warm. Judging that trouble was to be apprehended from the heart, I prescribed small doses of digitalis and whiskey to be frequently given during the night. She kept quiet and drowsy from this time, 10 P.M., till about 3 A.M., when she went asleep (probably became comatose), and died quietly about 6 A.M., fifteen hours after partaking, of the poison. She urinated freely after taking the draught, but I did not get an opportunity to examine the water. As I did not see her during the last eight hours of life, the immediate symptoms preceding death can only be guessed at; but I believe it might be said she died of "heart failure."—*Med. Rec.*, Dec. 28, 1889.

Thompson (E. A.) on Carbolic Acid in Typhoid Fever.—The patient, a young man aged twenty-one, lived in a house at which I had, during the early part of the present year, attended two consecutive cases of this disease. On being summoned I elicited a history of well-marked premonitory symptoms, including pains in the back and limbs, severe headache, lassitude, anorexia, vomiting, and rigors. On physical examination I found tenderness on pressure in the right iliac region, accompanied by gurgling and tympanites. Temperature 103.4°, pulse 95, tongue furred, patient apathetic and drowsy. I ordered the usual strict dieting, and prescribed a mixture containing minim doses of carbolic acid and two grains of quinine to be taken every four hours. On the second day of attendance I found the patient much better. Temperature subnormal; bowels, which had been somewhat constipated, relieved by a single foul liquid motion; no aperient had been given. For the following three days the temperature continued to be subnormal, although I had discontinued the quinine; it then gradually approached the normal, and never again rose above it. Beyond the appearance, on the fourth day of attenddance, of a few somewhat equivocal rose-colored spots on the back and abdomen, the characteristic eruption was not developed. By the seventh day all symptoms had disappeared, with the exception of occasional pain and a little tenderness on pressure in the iliac region. Taking together the well-marked premonitory symptoms, the condition of the patient when first seen, and the fact of two cases having previously occurred in the same house, I think I was justified in diagnosing typhoid fever, and in attributing its arrest and cure to the administration of carbolic acid.—*Lancet*, Dec. 14, 1889.

Edge (A. M.) on a Case of Peripheral Neuritis, Caused by the Inhalation of Bisulphide of Carbon.—Although it has long been known that workmen exposed to the fumes of bisulphide of carbon are liable to present symptoms resembling those produced by alcohol, it

is only comparatively recently that cases have been described in which inhalation of this substance has caused a form of paralysis corresponding to alcoholic paralysis. The case which I am about to narrate is a good example of this form of toxic paralysis.

The patient, a man thirty-two years of age, was admitted on March 3, 1888. For the greater part of his life he had worked in a coal mine; he had then been employed for three years in a foundry, and in April, 1887, he began to work in the "curing-room" of an india-rubber manufactory, where he was compelled to inhale fumes containing a large proportion of bisulphide of carbon, which is used in the vulcanizing process. He had always enjoyed the best of health until the beginning of his present illness; he had been a total abstainer for sixteen years, and had never smoked or had syphilis. Soon after commencing work in the india-rubber factory he began to suffer from headache, giddiness, and drowsiness; the tongue was dry, and the taste of the bisulphide constantly present. He did not take much notice of this, as all the workmen were accustomed to suffer in the same way when first employed. These symptoms disappeared in the usual manner in the course of a few weeks. In the beginning of January, 1888, the headache returned and was accompanied by delirium and delusions of sight, and he was compelled by frequent attacks of giddiness to take to bed on the 10th. So-called "rheumatic" pains were then felt in the knees and ankles, and the face and hands became yellowish in color. He was also subject to attacks of unconsciousness coming on suddenly and without cause while he was in bed. About the end of February the legs were noticed to be weak, and the lower halves of the legs felt numb. Sexual desire was abolished. On admission into the hospital the delirium and other cerebral symptoms had disappeared. The patient could neither walk nor stand without support, but on being well supported on each side, he was able with great effort to drag the toe of one foot about three inches in front of the other foot. As he lay in bed there was distinct drop-foot on both sides; he could barely move the toes, and could not perform dorsal flexion of the ankle. He was able to raise the heel from the bed slowly and with difficulty; the legs could be adducted forcibly, but abduction was weak. No wasting could be detected. The knee-jerks and the plantar and cremasteric reflexes could not be obtained, and there was no ankle clonus. Almost complete loss of sensation as regards touch, pain, and temperature existed below the middle of the leg. On squeezing the calf muscles some pain was complained of, not confined to the parts pressed on, but described as shooting upwards and downwards. The functions of the bladder and rectum were performed naturally. The upper extremities were perfectly normal in every respect. The faradaic contractility of the muscles of the legs was somewhat impaired; with the galvanic current the muscular contraction was normal, and contraction occurred with a weaker current on cathodal than on anodal closure. No vasomotor or trophic disturbance was present. Taste and smell were normal, but the patient complained of weakness of vision, interfering somewhat with reading. His color vision was unfortunately not tested until March 16th, when it was found perfect, and the range of vision (hand test) was found normal on both sides. (By this time, however, the defect of sight had almost disappeared.) The pupils reacted to light, and the discs were healthy. The only treatment adopted was rubbing and the internal administration of quinine. Improvement began to take place almost immediately. On the 16th it was noted that he could raise the heels from the bed with ease and could produce flexion of the ankles; abduction also was performed more easily. Some return of sensation was noticed in the left foot, where a smart prick was quickly felt, and the knee-jerks had returned to a slight extent. On the 23d the anæsthesia had entirely disappeared on the left side. He was able to walk with the help of an arm on each side. On the 29th he could walk unsupported; the knee-jerks were active on both sides, but the right leg and foot were still slightly anæsthetic. He was discharged on April 18th, walking well, although the left leg was slightly the stronger. He continued to show himself occasionally without any change being noted. On June 15th he presented himself after a stay at the seaside. He was then walking perfectly, both legs being quite strong, and no anæsthesia could be detected anywhere. There was, however, no return of the cremasteric or plantar reflex. Sexual appetite had returned.

This patient was not seen again until

Sept. 21st. He said that he had returned to the india-rubber factory, and had found employment not in the "curing-room," but in a different part of the building, where he was occupied in boiling the rubber. He said he was not at all exposed to the noxious bisulphide vapor, and felt quite well. On examining him, I was somewhat surprised to find a considerable amount of anæsthesia involving the right foot and lower third of the leg. The cremasteric reflexes were still absent, but the knee-jerks were unusually active. On cross-questioning him, I discovered that when the wind was in a certain direction the fumes generated in the "curing-room" were blown into the room in which he worked.

There can be no doubt that this case was one of peripheral neuritis, due to the toxic influence of bisulphide of carbon. Fortunately, owing to the fact of the patient being a total abstainer, alcohol was excluded as an etiological factor. Two similar cases have been recently described by Dr. Ross,[1] and three cases had been previously described by Dr. Alexander Bruce,[2] in all of which the disease had been contracted in india-rubber works. A remarkable feature in the instance just narrated is that, notwithstanding the severity of the symptoms, recovery took place with great rapidity, as one was enabled to prognosticate from the electrical reactions of the muscles. A reasonable explanation of this rapidity may be deduced from Dr. Buzzard's theory of the pathology of this form of neuritis.[3] He supposes that toxic multiple neuritis is due to an irritative influence produced by the poison upon the vaso-motor centres in the bulb and cord, causing a diminution in the supply of blood to the peripheral nerves, and leading, if long continued, to a degeneration of nerve fibres. On this hypothesis I think we must suppose that the irritation and consequent diminished supply of blood had lasted only long enough in this instance to produce a condition of lowered nutrition in the nerves without actual degeneration. Another noteworthy point is that the upper extremities were in no wise affected; in both of Dr. Ross' cases the extensors in the forearms were weak, and numbness and tingling of the hands were complained of; similar symptoms have been noticed in other instances.[4] Sensory disturbances are usually found to a greater or less extent in cases of peripheral neuritis, except in ordinary cases of lead palsy, but the degree of anæsthesia in the lower limbs in my case was somewhat unusual.

It may perhaps be inferred from the anæsthesia found in the right leg when the patient was last seen that a previous attack of this form of toxic neuritis may predispose to a second attack on renewed exposure to even a very small dose of the poison.—*Lancet*, Dec. 7, 1889.

Hutchins (W. D.) on Veratrum Viride in Exophthalmic Goitre.—A woman, above medium height, weight, ninety-three pounds, age, thirty-five, mother of three children, applied to me for treatment July, 1879. Her condition: anæmic, greatly debilitated, heart apparently much dilated, without rhythm, with a wallowing movement; eye-globes so protuberant as almost preventing closure of lids, presenting shocking deformity. Goitre not measured, but very prominent. Mind deranged. She had suffered with this malady, gradually increasing in gravity, for twelve years. Had been under the treatment of several home physicians, and, finally, while visiting Philadelphia, consulted a physician of that city, who diagnosticated exophthalmic goitre, and advised her to return home immediately, as she was liable to fall dead at any hour. I confirmed his diagnosis, and placed the patient on tr. veratrum viride, three drops morning and night, to be gradually increased until the full dose possible to tolerance was obtained. At first the three drops were barely tolerated; four drops produced such weakness as to oblige her to take to her bed for a short time. She persevered, however, until twelve drops were taken morning and night without producing nausea or any inconvenience whatever.

This dose was continued twice daily for twelve months, then dropped to one dose daily for a few following months.

The improvement of the patient was gradual but progressive, and at the expiration of twelve months from beginning of treatment the goitre had disappeared, the eyeballs had receded to their normal position, the mind had returned, and her weight was ascertained to be one hundred and

[1] *Medical Chronicle*, June, 1887.
[2] *Edin. Med. Journ.*, 1884.
[3] "On Some Forms of Paralysis from Peripheral Neuritis." 1886.
[4] Eloy, *L'Union Médicale*, Sept., 1886. Bruce, *loc. cit.*

sixty pounds.—*Therap. Gaz.*, December, 1889.

Busey (S. C.) on a Case of Exophthalmic Goitre Treated Successfully with Sulphuric Acid and Strophanthus.—I was recently called to see a young lady suffering with the disease. In her case the cardiac and thyroid symptoms were well marked. The exophthalmos was perceptible, but not prominent. It was more marked in the absence of harmony in the movements of the eyeballs and upper lids than in protrusion of the eyeballs. The right side of the thyroid gland was much larger than the left, but the enlargement at the base of the neck compelled her to enlarge her collars and to loosen the neck bands of her clothing. Her pulse was frequent and excitable; complained of palpitation and difficult respiration, especially when ascending steps. Slept badly, sometimes lying awake all night; was nervous, irritable, anæmic, without appetite, constipated, and had a slight cough. In general appearance she looked like one suffering with phthisis pulmonalis. I ordered two drops of the tincture of strophanthus every six hours, and ten drops of aromatic sulphuric acid every four hours, an easily digested and nutritious diet, food to be taken during waking time every four hours, early retirement and remaining indoors during inclement weather and after sunset. The course of treatment was twice interrupted, once by the illness and death of a member of the family, and again by a severe attack of bronchitis, induced by indiscreet exposure in making a visit to the cemetery. Improvement was manifest soon after the beginning of the treatment, and now she seems to be perfectly well, with entire disappearance of the thyroid enlargement. The action of the heart is good, her appetite is excellent, bowels regular, sleeps well, is bright and cheerful. She is vigorous, with rosy cheeks, and a gain of twenty-five pounds in weight.—*Jour. Am. Med. Ass'n*, Dec. 7, 1889.

Main (R.) on the Iodide of Ethyl.—I have found iodide of ethyl in 10-minim doses, sprinkled on a handkerchief and then inhaled, extremely beneficial in cases of bronchitis and bronchial catarrh, complicated with Bright's disease and fatty heart with feeble circulation, and especially when the bronchial secretion is viscid and there are urgent symptoms of dyspnœa. About five minutes after the inhalation the patient coughs and expectorates freely, which relieves the distressing dyspnœa. I administered it in a case presenting very severe symptoms of dyspnœa, amounting to complete orthopnœa, in a patient over 60 years of age. The ordinary expectorants—carbonate of ammonia, senega, ipecacuanha, lobelia, squills—combined in full doses, were given with very little effect so far as the acute symptoms were concerned. After two hourly inhalations of the iodide my patient was able to lie in bed and have a five hours' sleep, and I must say after such inhalation there was free expectoration. I trust that readers may be induced from the above notes to prescribe the iodide when they have similar cases to deal with.—*Br. Med. Jour.*, Nov. 30, 1889.

Richman (S. T.) on a Fatal Case of Carbolic-Acid Poisoning.—On July 25, 1889, at the noon hour, a child seven months old received a superficial burn on the left arm and thigh from a cup of hot coffee. A mixture, consisting of equal parts of carbolic acid and sweet oil, was applied by the mother, being a recipe taken from a domestic medical book in her possession. About half an ounce of 95-per-cent. carbolic acid was thus used. In two hours the child passed into a condition of stupor, which, continuing, alarmed the family, and I was summoned.

Arriving at 7 P.M., I found the child lying quietly, with the exception of an occasional movement, made by flexing the legs upon the thighs and these upon the abdomen, and then forcibly extending them. The eyes were fixed, the pupils contracted to the size of a pin's head, the pulse 120, weak, breathing irregular, occasionally sighing, swallowing performed with great difficulty, mucus expectorated rather than vomited, the odor of carbolic acid being plainly perceptible in the breath.

Not having atropine with me, I administered four minims of the fluid extract of belladonna by the mouth, a portion of it being rejected. At the end of an hour the pupils had begun to dilate, a slight blush was barely perceptible, and swallowing less difficult. A small quantity of whisky was then given with two minims of belladonna.

At the end of another hour the pupils were normal, the erythematous blush quite

perceptible, swallowing somewhat improved, pulse and respiration the same. Learning that no urine had been passed since noon, and not desiring to substitute belladonna for carbolic-acid poisoning, I discontinued the former and ordered small doses of nitrate of potassium and whisky to be given at intervals during the night.

At eight o'clock next morning the pulse was 160, weaker, temperature 103° F., face blanched, pupils larger than normal, eyes fixed, the child lying quietly. The mother showed me a napkin with a dense smoky stain, three of which had been removed during the night, adding that the stains would not wash out. The child continued to grow weaker, the pulse rising higher, until convulsions set in at five o'clock, and death occurred an hour later —thirty hours from the application of the acid.

No post-mortem was allowed.—*N. Y. Med. Jour.*, Nov. 30, 1889.

Sangree (E.) on a Strong Solution of Argentic Nitrate as an Injection.—A. G., a young man of twenty-five, contracted gonorrhœa in October last. He went to a physician, who put him on the acetate and the bromide of potassium, in three weeks prescribing a mild injection of zinc sulphate. The inflammation at this time evidently extended back to the bladder, for the patient had incontinence of urine. The injection was kept up for some weeks without apparently much good effect. There was never much pain or discharge, and after a time the incontinence ceased. His physician now tried a number of different injections with no result, and the patient finally drifted into my hands. I tried successively mild injections of nitrate-of-silver solution, bismuth, sulphate of zinc, Mitchell's bougies, and his post-urethral syringe. There still remained a a slight oozing of a mildly purulent character. But upon using once a day this preparation,

℞ Ext. hydrastis fluidi . . . . f ℥ j.
Bismuthi subnitratis . . . . ℥ j.
Boroglyceridi
Mucil. acaciæ . . . 5 ℥ āā ℥ ss.—M.,

more or less diluted, the discharge was reduced to a few drops daily of a serous fluid, and there was some pain at each urination. Bougies were now tried, with the result of finding a slight restriction of the urethral calibre about two inches from the meatus, and an exquisitely sensitive prostate, showing a subacute inflammation there. By this time the patient had been under treatment six months—three under the first physician, and the same under me, —and as he manifested a disposition to go elsewhere—as the bougies seemed to be doing little good,—and as he would not submit to urethrotomy, I decided to resort to a rather strong measure to restore firmness to the relaxed mucous membrane of his urethra.

First, I injected a drachm of a 10-percent. solution of cocaine, holding it in five minutes. The excess I washed out by an injection of warm water.

I now injected a drachm of a strong solution of nitrate of silver, gr. x to ℥ j., allowing it to remain in about two minutes.

The only pain experienced was some burning afterwards, which I stopped with another injection of cocaine. The penis shortly began to swell, and to discharge pus quite freely. I put the man to bed and had him keep the parts wet all afternoon with lead water and laudanum, which kept down the pain and swelling. By morning the swelling was nearly gone.

For several days there was pain on urinating, but this was rendered slight by large doses of acetate of potassium.

The point of this account is that from the time of recovering from the effects of the nitrate of silver, the patient has had neither pain in nor discharge from his urethra.—*Times and Register*, Nov. 16, 1889.

BOOK NOTICE.

A Compend of Human Physiology.—By Albert P. Brubaker, A.M., M.D., Demonstrator of Physiology in the Jefferson Medical College, Professor of Physiology, Pennsylvania College of Dental Surgery, etc., etc.

This compend, which has reached its fifth edition, appears to be one of the best of its class. The part of the little volume most to be commended is the portion which treats of the nervous system. This subject takes up over one third of the one hundred and eighty-three pages. The plates of the spinal cord and brain are excellent, and the treatment of the special senses is especially good. A valuable addition to the subject-matter of the compend is a table of physiological constants.

E. S. B.

THE MEDICAL ANALECTIC AND EPITOME.

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE.

EDITED BY R. W. AMIDON, M.D.

VOL. VII., No. 2. February, 1890. WHOLE No. 154.

THERAPEUTICS.

Creolin as an Excellent Provoker of Suppuration. —The antiseptic and germicidal powers of creolin have been much vaunted of late. Some chemists, however, have watched with jealousy the new drug of unknown and secret composition. Janowski of Varsovia, according to Dr. E. Malvoz, has been experimenting with this new product, among others, and finds that it is an active pus producer. Of all the products experimented with (concentrated acid, alkalies, products of putrefaction, etc.) by this chemist, creolin was one of the few substances capable of producing suppuration *by itself without the least intervention of micro-organisms.*

The purulent secretion excited by creolin is devoid of micro-organisms. The creolin injections were of different strengths and made in various locations of the bodies of the animals experimented on, and suppuration commenced in about three days in all instances.—*Anns. de la Soc. Méd-Chir. de Liège*, Dec., 1889.

Wilkoit (J. W.) on the Treatment of Indolent Ulcer.—In the first place the patient should be kept as quiet as possible; the limb should be bandaged from the toes above the sore, and should be kept elevated, *i. e.*, if the patient is allowed to sit in a chair he should prop the sore limb up above the well one and keep it at rest. One should apply to the sore, every other day, subnitrate of bismuth, and wash the sore, every three or four days, in a carbolized solution.

If the surface looks very pale, and the edges are hard, it is well to pare them off with instruments or touch occasionally with sulphate of copper (stick).

I give the following prescription as my internal treatment:

℞	Ext. stillingiæ	f ℥ ij
	Ext. lappæ	f ℥ j
	Ext. phytolaccæ	f ℥ ss
	Syr. sarsaparillæ q. s. ad	f ℥ vj

Misce. Sig.: Teaspoonful three times daily. If one be sure the person has a syphilitic taint, the iodide of potassium should be added to the above prescription.

The most discouraging feature in treating the indolent ulcer is that it does sometimes recur—that is, after it is apparently well it breaks out anew; but to avoid this the patient should take the internal treatment for some time after he thinks he is well.—*Kansas City Med. Index*, Dec. 1889.

Post (S. E.) on Boric Acid and Alcohol in the Treatment of Acne.—The solution employed consists of half an ounce of boric in eight ounces of alcohol, to which perfume may be added, if desired.

The directions for treatment are as follows: Bathe the face at night in hot water containing a few drops of ammonia; do not use soap. Rinse the face in cold water. Dry the face. Then apply the solution, sopping it on with the corner of the handkerchief or soft, clean rag. In the morning do not wash the face, but apply the solution. Carry the solution with you, and apply it several times a day if the skin becomes moist.

In very bad cases apply a little ether and remove the comedones with the extractor at the time of the visit. Within a week great improvement should be obtained.

Unlike most applications to the skin, the boric-acid solution forms an elegant toilet preparation, as it deposits a delicate powder which is scarcely perceptible, and yet serves to remove the "shine" from the face. It has been thought that the alcohol might

be the active agent in the cure of acne, but without the powder which it carries the alcohol would not be tolerated, as it leaves a glistening surface on the skin.—*Med. News*, Jan. 18, 1890.

Allyn (G. W.) on Iodine in Middle-Ear Disease.—In some ears the seat of a chronic discharge, the author often finds a whitish, tough aspergillus-like mass of very rapid growth, which is very adherent and rebellious to iodoform, mercuric and strong silver-nitrate solutions. The author protects the deeper parts of the ear with vaseline, and then mops the outer canal freely with a mixture of tr. iodine and glycerine, washes it out with water, and then applies iodoform. This treatment he finds very efficacious.—*Med. Standard*, Jan., 1890.

Johnston (R. M'K.) on the Use of Papaïn in Ear Diseases.—In papaïn, the author thinks, we have a drug capable, by its digestive action, of thoroughly cleansing the ear in those cases in which simple syringing is insufficient.

Fifteen minims of a 5% solution of papaïn is dropped into the ear, care being taken that it reaches the bottom of the meatus. The ear is syringed out in one hour with a boric-acid solution and carefully dried.—*Edinburg Med. Jour.*, Jan., 1890.

Leplat on the Application of Ointments to the Eye by Means of a Glass Rod.—Disgusted with the ordinary methods of applying remedies to the eye, the author has sought some simple way to avoid their irritating and uncleanly results. He takes small glass rods with rounded extremities, and the end destined to penetrate the conjunctival sac having a diameter of from 1.5 to 2 millimetres, he curves to an angle of about 135°.

These rods cannot hurt the eye, and they can be disinfected if wished.—*Annales de la Soc. Méd.-Chir. de Liège*, Nov., 1889.

Knight (C. H.) on Menthol in Laryngeal Phthisis.—The author uses a solution of menthol in fluid albolene, in the proportion of a drachm or a drachm and a half to the ounce. Even with the weaker solution a good deal of irritation and cough is sometimes excited, while some cases bear the stronger solution without much complaint. Patients are directed to inhale ten or twelve drops of the solution from the surface of steaming hot water, or a few drops are thrown over the ulcerated surface with a laryngeal spray or syringe, or the application is made directly with a pledget of cotton. In the latter case a 10 % solution of cocaine must first be sprayed into the larynx. The easiest and perhaps the most effective way is found to be by inhalation for a few minutes every half hour from a nebulizer or vaporizer. The medicated vapor no doubt reaches the bronchi as well as the larynx, and is probably deposited on the mucous membrane of the entire air tract, provided the patient is directed to hold the breath for a few moments after taking an inspiration.

Menthol seems to be a drug which has a peculiar sedative effect in tubercular laryngitis. To most patients it is soothing and grateful. Under its influence hyperæmia is diminished and secretion is lessened. In some cases cough and dysphagia are relieved. It may encourage a tendency to cicatrization, which is now and then witnessed in tubercular ulcers of the larynx even without special treatment. It is not unusual to observe displacement of a sloughy surface by apparently healthy granulations, and an attempt at repair begins. The author has not seen a well-defined tubercular ulcer of the larynx completely heal under its use, although, in many instances, superficial erosions, "catarrhal ulcers," perhaps due to irritation from cough and perverted secretion, have disappeared. The beneficial effects of menthol are obvious, and in propitious cases a cure is feasible.

The author does not rely wholly on local treatment, but gives cod-liver oil, hypophosphites, arsenic, and iron when indicated.

The author concludes that:

1. Spontaneous cure of a tubercular ulcer of the larynx may occur.

2. A simple erosion or ulceration may be mistaken for a tubercular ulcer.

3. The best results from local treatment of the larynx may be expected in cases of incipient or limited pulmonary disease, and in primary laryngeal tuberculosis.—*Fr. Am. Med. Ass'n*, Jan. 18, 1890.

Calomel in Diphtheria.—Dr. J. J. Green, of Pittsburg, Pa., details his method of treating diphtheria:

The family had lost two children, one of them just one week previous. The child had nasal diphtheria; the membranes had grown down so as to be distinctly perceptible. Small membranes on both ton-

sils. He gave large doses of calomel frequently administered, and made a tampon of absorbent cotton wet with a solution of mercury bichloride, one to a thousand, and plugged the nose as completely as he could. He allowed it to remain twenty minutes. Before doing this he syringed the nose thoroughly with a solution of borax, and left some of the mercury solution, telling the mother to place the cotton every two hours. The same evening he applied iodoform, reduced with calcined magnesia. The next day at ten o'clock the membranes had entirely disappeared from the nose and throat. Hemorrhages occurred frequently, but there was no reappearance of the membranes.

He administered to the first patient about 120 grains of calomel in the first twenty-four hours.

Dr. Lange gives 5 grains of calomel every hour to diphtheritic infants without causing salivation or purgation. To one boy he gave 500 grains of calomel in 10 days without producing salivation or purging, the boy recovering.—*Med. Standard*, Jan., 1890.

Kennedy (C.) on the Treatment of Peritonitis.—Speaking for myself, with thirty years' active practice, I pronounce the opium treatment a miserable failure. All patients do not die under the opium treatment, but 75 *per cent.* of them do.

My plan of treatment is simple, and easily stated. I give at once, and repeat at least every hour, good round doses of saline cathartics, until I get at least eight or twelve good alvine discharges. If the stomach rebels, I give 10 grains of calomel each hour. If I do not hear from the saline or the calomel in four hours, I place the patient on her left side, raise the hips, and employ as an enema 1 oz. of some saline cathartic in half a pint of water, and repeat every hour if necessary. I place compresses, wrung out of well-water, over the abdomen, and if the compresses are thin, I change them frequently. If the pain is intense, I inject under the skin ¼ grain of morphine, and repeat it if necessary. If after a fair trial of this treatment for 36 hours—after I have procured from 10 to 20 operations from the patient's bowels—the patient is not decidedly better in pulse, in temperature, in tenderness on pressure, and in countenance, open the intestine and let out the gas and fluids, and sew it up. Flush the cavity thoroughly with a solution of corrosive sublimate, and dress the wound antiseptically. Of course there are many details of treatment and operation that you will not expect me to give now—your judgment will suggest them.

Dr. Alonzo Clark, in commenting on a case in which recovery followed a laparotomy for acute peritonitis, says: "If the future supports the practice in this case, acute general peritonitis is likely to become a surgical disease rather than a medical." In my judgment, the hour is here. The great progress made in abdominal surgery and antisepsis in the past few years increases the chances of recovery in hopeless cases of acute general peritonitis, certainly fifty per cent.—*Am. Lancet*, Dec., 1889.

The Treatment of Acute Catarrh of the Rectum.—Quite frequently the practitioner of medicine sees cases in which the entire list of remedies generally found of value in the treatment of diarrhœa have proved useless, or merely palliative in effect. While they may control the frequent movements of the bowels for a time, the trouble reasserts itself, as soon as the medicine is withdrawn, at the best in a somewhat modified form. Careful inquiry will show, in such cases, several points of value as to diagnosis and treatment. The attack has probably been preceded by a few days during which there has been a sensation of weight or fulness in the rectum and about the anus; following this, a sensation of bearing down asserts itself, accompanied by violent pain referred to the region of the stomach, or small gut. So severe is the pain in its paroxysms that the patient may cry out with it, and the perspiration break out over the body. At first small passages may occur, but after a few stools they consist of wind and a few drops of mucous, which is expelled after a period of agonizing pain and tenesmus. Opium makes the state ultimately far worse than before, and nearly all astringents are valueless. Under these circumstances, small doses of chlorate of potash injected into the rectum are most serviceable, only one or two injections being necessary in some acute cases to produce a cure. A saturated solution of the potash in water should be employed, and about half a tumblerful injected each time, very slowly and without force, and retained for ten or fifteen minutes. Large injections will cause pain

and expulsion of the liquid, and no result will be attained.—*Med. News*, Dec. 28, 1889.

Reynolds (E.) on the Value of Salicylate of Soda in Dysmenorrhœa.—The deductions of this paper are from a study of fifteen cases of dysmenorrhœa. One was a case of general pelvic congestion, with an anteflexed cervix and an ill-developed uterus; the patient was packed on alternate days, and was given salicylate of soda, and the next catamenia was for the first time painless. One was a case of stenosis of the internal os, was treated by the use of dilators, and the salicylate of soda was administered in anticipation of the catamenia, with marked relief of pain; but in neither of these cases does it seem safe to ascribe the improvement to the use of the salicylate of soda alone.

Of the remaining thirteen, three were found to have anteflexion of the cervix, three had catarrhal salpingitis, one was the subject of a membranous dysmenorrhœa (?), and one was affected with a bad endocervicitis; making eight cases in which a cause for the existence of the pain was found. Of the others, in two the pelvic organs were thought to be normal; in two no examination was made; and in the remaining case symptoms apparently due to a cystocele and a slight prolapse of the uterus were relieved by a pessary, without effect upon the very severe dysmenorrhœa, for which no cause was found; in all, five cases in which the symptoms were unexplained.

Of the three cases of anteflexion, one was not improved, one was partly and one completely relieved; no other treatment having been employed. The three cases of salpingitis were all promptly and completely relieved so far as their dysmenorrhœa was concerned; although the improvement in the local condition was much more gradual and less marked. The case of membranous dysmenorrhœa was somewhat but not wholly relieved, by her first experiment with salicylate, which she has not had time to try again; the patient with endocervicitis said on her next visit, that she had "come round without knowing it, a great change." She continues its use, and remains well. Of the five unexplained cases, both patients with apparently normal organs were completely relieved, the case of cystocele and prolapse with dysmenorrhœa from unknown cause was also completely relieved; of the two who were not examined, the pain was wholly controlled in one, while the other was unrelieved. This latter patient was suffering from a sharp attack of probable subacute pelvic peritonitis, and was possibly not a fit subject for the experiment, but is added to the list for the sake of fairness.

In conclusion: of the thirteen cases, nine were completely, and two partially, relieved; while in two the treatment was without effect. In two of the cases (one normal, one of salpingitis) the omission of the salicylate was followed by a return of the pain, and at the next catamenia its resumption resulted in a painless flow. The gratification expressed by the patients has been so great, and we ourselves have been so much satisfied with the use of the drug, that we have ventured to report this small series of cases, in the hope of provoking further observation of its value, and especially of the best method of administration. It was given to all our cases in ten-grain doses, t. i. d., for the week which preceded the catamenia, and continued until the time when the pain usually disappeared; but it is an open question whether the same or larger doses given during a shorter time might not have been equally or more effective. We are unable to judge whether any permanent benefit resulted, and we wish to say that we ourselves consider this report as a mere preliminary to further observation, which, with a larger number of cases, may, of course, largely alter the proportion of relief obtained.—*Boston Med. and Surg. Jour.*, Dec. 19, 1889.

Guénoit on the Treatment of Uncontrollable Vomiting of Pregnancy.—According to the author, three organs combine in producing the vomiting of pregnancy: the uterus, the nervous system, and the stomach. The three indications are: first, to allay morbid or abnormal excitability of the uterus by belladonna, cocaine, morphine, vaginal injections or appropriate topical applications; a Gariel pessary, elevation of the pelvis with decubitus of the trunk on an inclined plane, cauterization or even artificial dilatation of the cervical canal, are measures which should be undertaken in different cases with hope of success; secondly, the activity or exaggeration of reflex transmission should be diminished or repressed by the use of chloral and bromides, or by refrigeration of the spine or by moral influences;

thirdly, by calming the erythism of the stomach by a rigorous diet, by suppressing all sour drinks, by the use of the waters of Vals or Vichy or ice in small quantities, by flying blisters or blisters with morphine on the epigastrium, by ether spray occasionally on the same region, and by a regulation of the bowels. In all these modes of medication the stomach should be spared and the remedies be given as much as possible by the rectum and through and under the skin.—*Revue Méd.-Chir. des Maladies des Femmes*, Nov. 25, 1889.

Pepper (W.) on the Continuous Use of Blue Mass in Small Doses.—The patient was a man of large frame, about fifty-five years of age, whose occupation or habits prevented him from getting sufficient sleep, as he rose each morning by 4 or 4:30, although he did not retire until 11 P.M. Evident signs of heart failure began to show themselves about a year ago, with dyspnœa on exertion, difficulty in going up-stairs, or lifting weights, increasing œdema and albumen in the urine without casts. He had been treated in various ways, chiefly by iron in conjunction with diuretics, as acetate of ammonia or nitrate of potash. The symptoms steadily increased until the œdema invaded the trunk and genitals, and he was almost confined to his room. When he came under treatment repeated trial was made with similar remedies, but finding no good result, and that the digestive system was in fairly good condition, the following pill was ordered :

℞ Mass. hydrargyri
Pulv. digitalis
Cinchonidiæ sulph. . . . āā gr. xl
Fiat mass. et div. in pil. No. xl.
Sig. : One pill three times a day.

These pills were begun November 10th, and were continued regularly until November 22d by which time the full number had been taken. He was also ordered to remain in bed until 7 o'clock each morning, thus securing at least eight hours' rest. During the day he was directed to lie down for one hour.

The only appreciable action of the remedy was a steadily improving tone of cardiac action with increased secretion of urine, with diminished proportion of albumen, and progressive decrease of œdema. By November 22d all the symptoms had disappeared, the urine was free from albumen, and the œdema was entirely gone. There had been no purgation, and no evidence of mercurial action. The change in his appearance was extraordinary, as he seemed shrunken away, showing that the entire body had been infiltrated with serum. He felt weak, but the only remedy ordered was an ounce of whisky twice daily. Upon this he has rapidly regained his strength, and now seems in very good condition and ready to return to work.

I have in some cases of general œdema, both with weak heart and with organically diseased heart, given the above combination for much longer periods than in this case, and with remarkably good results, but in other cases it becomes necessary to suspend very soon, chiefly owing to gastric disturbance. If the mouth is frequently washed with a solution of chlorate of potash, there does not seem much danger of ptyalism ; but a constant close watch for this should be kept up. The remedies should always be joined with carefully regulated hygiene and diet.—*University Med. Mag.*, Jan., 1890.

Folsom (C. F.) on the Treatment of Typhoid Fever.—In the years 1887, 1888, and 1889 the author has had an average mortality of 8.66 % among the typhoid-fever patients in his hospital practice.

Unless diarrhœa is present he gives a single calomel purge. He gives food more freely than some do and often uses nutrient enemata. He uses alcohol sparingly and gives wines in preference to spirits.

He never employs the cold bath but occasionally sponges the patient. As an antipyretic and analgesic he employs phenacetin in hourly doses of twenty grains. For sleeplessness he avoids chloral and the bromides and prefers paraldehyde, amylenhydrate, or even opium. He checks the diarrhœa earlier than some advise, and his whole treatment is supporting. When weakness of the heart manifests itself he alternates digitalis, nux vomica, and iron with strychnia and caffeine, avoiding coca and camphor. He studiously avoids overstimulation.—*Boston Med. and Surg. Jour.*, Dec. 12, 1889.

Cutler (E. G.) on Some Hospital Cases of Typhoid Fever.—From July 1st to Nov. 1st the author treated fifty-six hospital cases of typhoid fever with a mortality of about 9 %.

The diet was plain or peptonized milk. A daily sponge bath was given for cleanliness, and if the temperature rose to 102.5°

a sponge bath of 65° was given every three hours. At 105° ice-water baths were given hourly. If the temperature continued high phenacetin was given in four-grain doses, the subsequent fall to near the normal point giving way to a gradual rise in from six to twenty-four hours to a point a little below where it was before. It also gave the patient a quiet restful night.

When cardiac stimulants were needed, ¼ grain doses of cocaine every four hours, nitro-glylycerine one minim of the 1 % solution every three hours, and a small dose of sulph. atropiæ at the same intervals were given. These stimulants be it remembered were only for emergencies.—*Boston Med. and Surg. Jour.*, Dec. 26, 1889.

Bonning (C.) on the Treatment of Typhoid Fever.—In five years the author has treated (in private practice?) sixty cases of typhoid fever without losing a case.

Of these sixty cases nine were treated exclusively with cold baths after Brand's method; forty-one were treated with the cold pack and the internal administration of carbolic acid and tincture of iodine; and in the remaining ten, the only really mild cases in this series, cold sponging was substituted for the cold pack, whilst the internal use of carbolic acid and tincture of iodine was adhered to, the same as in the forty-one severe cases.

Three cases of relapse and three cases of severe intestinal hemorrhage were among the group of forty-one cases, whilst no other serious complications or sequelæ occurred amongst the whole series of sixty.

In all cases treatment was commenced with one or two large doses of calomel, and no other medicines were employed during the duration of the sickness, except in a few cases, when one or two large doses of quinine were administered in the first few days in order to establish diagnosis, and in a very small number of patients in which the diarrhœa was too severe and persistent a few large doses of subnitrate of bismuth were given. Also in those three cases of intestinal hemorrhage, besides cold compresses being applied to the abdomen, opium was given internally for a few days, until the danger from this serious complication had passed.

An exclusive diet of milk, meat-juice, broth, tea, coffee, and wine was in all cases adhered to from the beginning, until convalescence was fully established.

The author is perfectly convinced that this is the ideal treatment for typhoid fever, and the very best which can be used in any and every case of this disease, whether it be of mild or severe type.—*Phys. and Surg.*, Dec., 1889.

Wilson (L. J.) on the Treatment of Chronic Bright's Disease.—According to the author, Bright's disease is particularly fatal in his neighborhood (Arkansas and Northern Mississippi). Dissatisfied with the routine treatment of the disease the author employed and claims excellent results from the use of creosote, iron, and ergot. He gives two drops of pure creosote with twenty drops of tincture of chloride of iron before meals and a teaspoonful of fluid extract of ergot in water after meals.—*Memphis Med. Mo.*, Dec., 1889.

Taylor (R. W.) on Some Practical Points in the Treatment of Syphilis.—The author is not one of those who commence specific treatment as soon as the character of the initial lesion is made out. According to him, "syphilis is not mature until the date of secondary manifestations, when the newly formed, young, round, infecting cells are proliferated in vast quantities and are thrown into the general circulation, and by it carried throughout the body. When this has occurred, I think syphilis may be said to be 'ripe'; then, and not till then, we have something tangible to treat. At this time, mercury introduced into the organism can exert its marvellous powers in destroying this, then, young, nascent, infectious material, and in causing its absorption."

He thinks we are unable to abort the disease in its first stage.

Ignoring the expectant and the spasmodic or interrupted method of treatment, the author advocates the continuous and tonic treatment of the disease. He favors the internal use of the green iodide in doses of from ¼ to ½ a grain three times a day in pill form, or from ½ to 1 grain doses of the tannate of mercury, the dosage of either remedy depending on the age and robustness of the patient.

The general health of the patient must be kept at the very highest point, the soundness of the mouth, pharynx, and stomach being an object of especial anxiety.

He favors inunctions at times as a change, and particularly when cutaneous lesions are present, having satisfied himself that the local action of the remedy is salutary.

He remits treatment occasionally when a

lull in virulent manifestations occurs, lengthening the intervals in the second year, when he combines his remedy with some iodide of potassium.

He believes that at times there is an advantage in bringing the application near the lesion, hence he frequently uses inunctions over or hypodermatic injections about indolent glandular enlargements, inunctions about the neck and jaws, temple and occiput, in early and late meningeal and cerebral disease, and after cleansing antiseptically mucous patches and condylomata, he dusts them with calomel.

In some cases where rapid action is necessary, when the lesions are on the face, neck, hands, etc., the author resorts to the subcutaneous employment of the drug, but he is wisely conservative in this use of the remedy, and countenances only the employment of a soluble preparation in this way.—*Med. News*, Dec. 7, 1889.

Dreyfous on Antisepsis of the Urinary Organs by Internal Medication.—The conditions to be fulfilled by an antiseptic of the urinary organs are: it must be slightly soluble, must have no toxic action, must be neither an antipyretic nor a general antiseptic, nor even an intestinal antiseptic, but must reserve all its action for the urinary organs. According to the author, salol, which in the intestine is decomposed into carbolic and salicylic acid, is such a drug. Both ingredients are eliminated by the urine, the latter acid unchanged, the former as a sort of sulphocarbolate.

The author gave salol in doses of from gr. lxxv. to gr. cxx. alone or with balsamics, to seven patients and found it well borne by all, and in all cases gonorrhœal discharges were rapidly benefited. In one case of four days' standing perfect recovery was brought about in three days. An association of cubebs or copaiva with salol seemed advantageous—*La France Méd.*, Nov. 30, 1889.

Smith (A. H.) on Saccharin as a Means of Acidifying the Urine.—The mineral acids when taken into the stomach are chiefly eliminated by the intestinal mucous membrane, and the only way in which they affect the reaction of the urine is by liberating from their bases the organic acids which in the form of salts they may chance to meet in their passage through the system. The organic acids thus liberated may or may not find their way through the kidneys. As a matter of fact, they generally do not succeed in running the gauntlet. Indeed, so slight is their chance of doing so that in practice, in prescribing a salt of an organic acid, we leave the acid entirely out of consideration.

The only acid heretofore employed with any degree of confidence that it would get beyond the kidneys, was benzoic acid. Even this does not reach the urine in its original form, but is converted into hippuric acid by the way. Nevertheless, it is in some degree useful in rendering the urine acid, but its action is not as certain nor as constant as might be desired.

When saccharin was first announced, it mentioned among its properties that it was unaffected by the digestive fluids, and was eliminated unchanged in the urine. Some time later, having had occasion to manipulate somewhat with this substance, I was struck with its strongly acid property, and it occurred to me that so decided an acid, of such a stable composition as to resist decomposition in the system and electing the kidneys as its way of exit from the body, would supply exactly the agent required for acidifying the urine.

An opportunity to put this idea to the test was afforded by a patient in my wards at the Presbyterian Hospital. This was a boy suffering with transverse myelitis, whose urine, which required to be drawn with the catheter, was ammoniacal and very offensive. A few grains of saccharin administered three times a day promptly changed the reaction of the urine to acid, and did away completely with the offensive odor. Not only so, but the irritation of the bladder became less, and the formation of pus was diminished.

Shortly after this I was in attendance upon a case of subacute meningitis in a child twenty months old. The urine, which dribbled constantly into the diaper, was alkaline, and its odor, though not ammoniacal, was peculiarly sickening. Every effort was made in the way of cleanliness, but the atmosphere about the bed was extremely disagreeable. Small doses of saccharin were prescribed, and immediately removed the fetor, to the great relief of the parents and attendants.

On beginning my service at the hospital, on October 4th of this year, I found a young woman, aged eighteen, in the ward, who was suffering from acute cystitis, apparently induced by suppression of the

catamenia and the absence of an evacuation of the bowels for seven days.

She had then been ten days in hospital. On admission, three weeks after the onset of her illness, the urine was alkaline, and contained a large amount of ropy mucus and pus. An attempt to wash out the bladder was abandoned, on account of the severe tenesmus excited. The contact of the catheter with the wall of the bladder caused hemorrhage.

Citrate of potassa was ordered, but gave no relief. When I came on duty I found the patient in so much distress that I suspected she had introduced some foreign body into the bladder. October 13th, finding the urine very alkaline, I directed the administration of five grains of saccharin three times a day. The following day the urine was neutral, and in four days more it was acid, and contained no mucus and but very little pus. October 23d, the urine was entirely normal, the symptoms had disappeared completely, and the patient was discharged cured.

It is probable that a part of the efficacy of saccharin in these cases is due to its being a powerful antiseptic in addition to its acid property.—*Med Record*, Nov. 16, 1889.

Christian on Ergotinine in the Epileptic Attacks of General Paralysis.—The author rehearses the chief characteristics of the epileptiform attacks which supervene in the course of general paralysis, and calls attention, with perfect propriety, to the frequency and gravity of these accidents, almost a third of paretics dying from these attacks. A fatal termination is preceded by a series of attacks in which the temperature rises and stands at 105°.

The importance of other remedies led the author, following the suggestion of Girma, to employ subcutaneous injections of ergotinine. The results of this treatment surpassed his expectations and markedly diminished the death-rate in his service at Charenton. The solution he employs contains gr. $\frac{1}{60}$ (0.001) in ♏ xv (1 cc.) and one or two injections suffice to check the convulsive phenomena.—*La Tribune Méd.*, Dec. 19, 1889.

† Jones (C. D.) Results of Treatment of Epilepsy by Borax.—The writer subjected ten patients with epilepsy to the treatment by borax with perfectly negative results as to amelioration of the epileptic condition. Unlike some other observers he observed no injurious gastric symptoms from the drug.—*Boston Med. and Surg. Jour.*, Jan. 9, 1890.

Money (A.) on Pilocarpine and Naphthaline in Infantile Therapeutics.—The author advocates the use of sweating and non-sweating doses of nitrate of pilcarpine in cases of fits of various kinds, whether fits of the mental, motor, vasomotor, sensory, or trophic centres. He has had some, but by no means a large, success in severe cases of fits associated with organic disease. Naphthaline has been used as a deodorant; it was valueless or almost valueless in cases in which ulceration and sloughing were going on. He advocates the dry method of treating vaginal discharge in infants and children, whether scrofulous or not. Intestinal antiseptic irrigation every day for a month is spoken of as greatly benefiting a chronic catarrhal colitis associated or not with worms.—*Br. Med. Jour.*, Dec. 14, 1889.

Richet on Anæsthesia from the Intra-Peritoneal Injection of Chloral.—The author, bearing in mind the danger of inducing anæsthesia by the intravenous injection of chloral according to the method of Vulpian, sought to avoid the syncopal accidents frequent in that procedure by practising injections into the peritoneal cavity. This procedure is exempt from danger and exactly the requisite dose can be determined. In dogs for each kilogramme (lb. ii.) it requires .50 gramme (gr. viii.) of chloral and .0025 gramme (gr. $\frac{1}{25}$) of morphine to bring on a general anæsthesia in from five to eight minutes, which will last two or three hours.—*La Tribune Méd.*, Dec. 26, 1889.

White (W. H.) on Chloralamide as an Hypnotic.—The author's experience extends to twenty patients suffering from various ailments. Comfortable sleep was secured in all cases except two: in one case, an adult suffering from cerebral hemorrhage and delirium, and in another case, a man with rheumatic fever, delirium tremens and salicylic poisoning resisted the hypnotic action of the drug. It seems to act as an hypnotic in some cases where extreme pain complicates the sleeplessness. The author has seen no disagreeable immediate or after effects, and attributes its occasional slow action to the fact of its extremely slow solubility in water. He gives it dissolved in brandy, diluting the brandy, if

desired, with water. It should not be prescribed with alkalies or hot water (148° +) as both decompose it. The dose is from twenty to sixty grains. It is cheaper by one half than sulfonal and has not the disagreeable taste and smell of paraldehyde. —*Br. Med. Jour.*, Dec. 14, 1889.

Hydrochlorate of Apomorphine as an Antispasmodic.—An anonymous writer in the *Archives de Médecine et de Chirurgie pratiques*, Sept., 1889, has made a trial of the antispasmodic powers of the hydrochlorate of apomorphine and concludes that the drug given by the mouth in a daily dose of gr. $\frac{1}{4}$. for a long time exerts no effect on the epileptic attacks. The same medicament administered hypodermatically in doses of gr. $\frac{1}{15}$ to gr. $\frac{1}{12}$ has a palliative effect on the spasmodic phenomena of the disease, particularly when given at the moment of an attack. The remedy is in no way curative. The author is more sanguine that in hysteria the remedy will be found much more useful. He has also employed it successfully as an antispasmodic in the vomiting of pregnancy.

Carruthers (W. H.) on Iced Applications in Acute Articular Rheumatism.—The author reports six cases of acute articular rheumatism in which he obtained surprisingly good results from applications of iced cloths to the inflamed joints. The applications are renewed as soon as warm. He gives at the same time ten to fifteen grains of salicylate of soda every two or three hours, but to the cold attributes the speedy relief of pain and prompt recovery.—*Kansas Med. Jour.*, Jan., 1890.

Poisoning by Fousel Oil.—A remarkable case of poisoning by fousel oil is reported from St. Thomas' Hospital. A coal porter, finding a bottle full of some spirituous liquor beneath the seat of a public-house, forthwith consumed about half a pint of the contents. About five hours later he became unconscious, and was taken to the hospital, where the stomach was washed out. He remained comatose and cyanosed, artificial respiration being at one time necessary. In the evening, some sixteen hours after taking the poison, he seemed to wake up, and recognized his friends, though still dazed and stupid. Both his breath and urine were redolent of some spirit, resembling bad whisky with a dash of nitrite of amyl. He remained dull and heavy for some days, and for forty-eight hours he complained of a burning pain in the throat and stomach, and of frontal headache. The bottle from which he had drunk was subsequently obtained, and was found on examination to contain about half fousel oil and half spirit, the "finings" presumably from some distillery. The remarkable features of this case were the long interval between the time of ingestion and the onset of symptoms, the markedly depressant effect on the respirations, and the curious and unmistakable amylic odor given off by the patient, though not perceptible in the spirit. The fumes exhaled by the patient caused severe headache and giddiness in those attending him, and these symptoms lasted some hours. This is probably the first recorded case of poisoning by fousel oil, and therefore possesses a special interest.—*Medical Press*, Dec. 18, 1889.

MEDICINE AND PATHOLOGY.

Sollier (P.) on a Case of Essential Paroxysmal Tachycardia Terminating Fatally.—The patient, a woman of thirty-seven, entered the hospital June 19, 1889. She had never had any ailment, nor was she nervous. When twenty-six years of age, after an annoyance of some sort, she was suddenly seized, while eating, with very rapid palpitation of the heart, which lasted four months. Her legs, face, and belly swelled. Under digitalis the palpitations diminished little by little, and finally disappeared altogether. In the following eight years she went through four normal pregnancies in perfect health.

At the age of thirty-five, again after an annoyance of some sort, a transient attack of palpitation occurred. Digitalis and cupping seemed to relieve her. Ten days before entering the hospital a third attack came on, which compelled her to quit work and go to bed. She had no fever or pain but great oppression. On admission she had a small, feeble pulse of 216. The apex beat in the seventh space. There was no murmur nor irregularity, but the heart-sounds were of a fœtal character, systolic and diastolic sounds equidistant and of the same *timbre*. The face was flushed, and there was some œdema of the legs and a little ascites. The urine was

normal; there was no goitre, exophthalmos, vasomotor disturbance or tremor. There was some tinnitus in the left ear, and when excited she had a sensation of constriction at the stomach and sometimes bilious vomiting. In short, the patient was nervous but not hysterical. Bromide of potassium and digitalis failed to give relief, cyanosis appeared, signs of pulmonary congestion came on with a respiration of thirty-six and considerable dyspnœa. Ten wet cups, followed the next day by the abstraction of five ounces of blood, with a blister over the heart, did no good, and the patient died June 25th.

During this last illness the pulse ranged from 192 to 216. The temperature was never above normal until the night before death, when it stood at 100° F. At the autopsy there was found considerable ascites and a slight pleuritic exudation on the left side, some adhesions at the apex of the right lung, and a small infarction at the base of the lung behind. Intense congestion of the lower lobe of the left lung. The liver weighed twenty-nine ounces, and was of the nutmeg variety, the spleen normal. The kidneys were anæmic. The first part of the jejunum was voluminous and of a wine-red color and weighed seven ounces. On being opened it was seen to be the seat of very considerable sub-mucous hemorrhage, giving to the intestinal wall a thickness of ½ inch. This hemorrhage infiltrated the mesentery to some distance from its insertion, and seemed to be terminal. There were no ulcers in the bowel.

The pericardium was loaded with fat, and contained no fluid.

The heart weighed eleven ounces, and was of soft consistence. The mitral valve was 3½ inches in diameter, and its large leaflet was intensely congested on its edge and a little thickened. The other valves were normal, and the orifices of the coronary arteries healthy. The heart contained neither blood nor clots. The nerves were not examined.—*La France Méd.*, Dec. 12, 1889.

René and Péré on the Bacillus of Infectious Endocarditis.—This bacillus is cultivated on gelatin, and has a beautiful green color. The experimenters have reproduced an infectious endocarditis by introducing into the jugular a certain quantity of the culture, and the original bacillus has been found in the vegetations of the valves.—*La Tribune Méd.*, Dec. 26, 1889.

Dujardin on Successive Loss of Sight in Both Eyes from Embolism of the Central Artery of the Retina.—The patient, a man of sixty-eight, lost the sight of both eyes in the space of three months; that of the left, which was lost last, three days before the patient sought medical advice. The loss of sight in the right eye did not alarm the patient much as it was accompanied by no pain, and the patient got along pretty well with monocular vision, but when the left eye became affected, in exactly the same way as the right, a mist suddenly enveloped every thing, and complete blindness followed in a minute. The pupils became slightly dilated and irresponsive to strong light. The patient was strong for his years, and presented no signs of heart-disease. There were no cardiac or vascular murmurs, the pulse was regular without intermissions, rather hard, and the arteries rather atheromatous. The ophthalmoscopic appearances were those of embolism of the central artery of the retina.—*Jour. des Sci. Méd. de Lille*, Dec. 20, 1889.

Lang (W. S.) on Venereal Toxæmia.—A man of twenty-four complained of partial phymosis and a thick purulent discharge coming from under the foreskin. The left ankle was extended, painful, and swollen, and there was much œdema on the dorsum of the foot. Temperature 103.4°. The next day the right knee became the seat of synovitis.

On retracting the prepuce two phagedenic ulcers were found behind the corona. There was absolutely *no* discharge from the urethra, nor was there any history of an antecedent gonorrhœa. The disease ran the course of gonorrhœal rheumatism in a healthy young man.

The author thinks that a pyæmic or toxæmic condition resembling acute or subacute rheumatic arthritis may result from the absorption of morbid products in venereal cases, although the parts affected may be altogether outside of the urethra.—*Br. Med. Jour.*, Dec. 14, 1889.

Bond (C. S.) on the Diagnosis of Chronic Kidney Lesions.—Albumin in the urine probably means disease somewhere in the body. In so-called physiological quantities it probably may be referred to disease removed from the kidneys, and is as transient as the cause. In

pathological quantities it signifies either inflammation external to the kidneys or a lesion of these organs. Many patients do not pass albumin with evident kidney lesions. Albumin is inconstant and bears no relation to the extent of the lesion, but when present must be respected as a prominent factor in diagnosis. It generally makes its appearance a long time after other well-marked symptoms have existed, and the disease is grave when it exists in pathological quantities, and should not therefore be waited for.

Casts bear an intimate relation to albumin, but appear later. They are strong proof of renal inflammation, as they carry, usually, a part of its epithelium. Differential diagnosis of the varieties of kidney lesions can often be made from this fact, but casts, like albumin, are inconstant, many patients not passing them at all, and they always appear too late to be a factor in early diagnosis.

The specific gravity of the urine is not to be relied upon unless the mean specific gravity of many specimens is taken of known quantities of urine for twenty-four hours. This would mean a small amount of urea passed within this time, since it is the dominant salt eliminated. Therefore, why not test for urea at once?

Some outward manifestations of ill health always precede for some time, often years, the passing of albumin and casts. These symptoms are in common with well-marked kidney lesions and are not due to other discoverable physical causes. Cases often, without a change in these symptoms for years, begin passing albumin and casts. It is fair to assume, therefore, that the symptoms referred to are the result of some common cause, which precedes the pronounced kidney lesions. This common cause seems to be something which produces extensive and often remote inflammations of serous membranes, which at the time, or remotely, involves the kidneys. What this cause is, we can at present only conjecture, but many of its pathological effects might be turned to advantage in early diagnosis.

Urea is excreted in abnormally small quantities in cases of well-marked kidney lesions. It is also excreted in cases having the prominent physical symptoms without albumin and casts. It is interchangeable as a means of diagnosis with the outward signs of the disease—*i. e.*, a knowledge of the condition of ill-health being also a knowledge of the amount of urea passed, and *vice versa*. Urea is excreted in small quantities months and often years before albumin and casts appear, and therefore a knowledge of this excretion is invaluable as a diagnostic sign of early lesions. The diminished quantity of urea eliminated is the result of the constitutional disturbances which precede for long intervals of time the local lesion. Active treatment, which would not be beneficial in other diseases having some symptoms in common, identifies this, generally relieves, and frequently apparently cures.—*Am. Jour. Med. Science*, Jan., 1890.

Billaux on Cases of Nephritis without Albuminuria.—After a narration of seven cases of nephritis in which albuminuria was absent or infrequent, the author concludes that albuminuria in chronic nephritis is only a symptom, and can be constantly or temporarily absent. The inconstancy of albuminuria in Bright's disease is an important factor in diagnosis, and should teach the practitioner never to rely on the results of a single analysis. Albuminuria is frequently absent during uræmic attacks, according to the author. Certain ulcers of the stomach and duodenum are only accidents of the arteriosclerosis of Bright's disease, and, in cases of hemorrhage from the alimentary tract, chronic nephritis should always be suspected.—*Jour. des Sci. Méd. de Lille*, Dec. 20, 1889.

Augier on Cancer of the Ovary and Cancerous Peritonitis in a Child of Eight.—The tumor, enormous in this case, was accompanied by an abundant ascites, which necessitated repeated punctures. The tumor occupied nearly the whole abdomen, but its growth commenced from below, allowing tumor of the liver or spleen to be eliminated from the diagnosis, and was larger on the right than on the left side. There was no urinary trouble.

A microscopic examination of the tumor clearly showed its epithelial nature. Secondary nodules existed on the surface of the peritoneum, but there was no general glandular enlargement.—*Jour. des Sci. Méd. de Lille*, Dec. 20, 1889.

Musser (J. H.) on Primary Cancer of the Gall-Bladder and Bile-Duct.—According to the author, primary cancer of the gall-bladder is not a very rare disease. It occurs three times as often

in women, and more often before the age of sixty. Gall-stones may be an exciting cause in a person predisposed to the disease. The organ is not much enlarged, except by secondary dilatation. Metastasis is not widespread, and is chiefly by continuity of tissue, nor are adhesions or ulceration common. The most usual symptoms are pain, jaundice, emaciation, cachexia, and tumor, while indigestion, vomiting, irregularity of the bowels, and ascites are frequently present. Pain occurs in sixty-two per cent. of the cases, is at first ill-defined and later localized to the right hypochondrium, and is lancinating in character. Gradually increasing jaundice is present in sixty-nine per cent., and tumor in sixty-eight per cent. of cases. Complications are due to occlusion of ducts and secondary effects on liver and gall-bladder, ulceration and perforation of gall-bladder, and those due to metastasis in other organs. The disease generally lasts six and two-thirds months, and death is due to exhaustion, peritonitis, metastasis, and biliary obstruction.

As regards primary cancer of the bile duct, the author considers it less frequent than the same disease of the gall-bladder, and occurring equally in both sexes. The age of occurrence is about the same, but gall-stones are less frequent in disease of the duct. The gall-bladder is enlarged only by dilatation; metastasis is not common and is near at hand. Adhesions, ulceration, and perforation do not occur, but jaundice is very frequent from occlusion of the duct, which makes the disease short and is directly or indirectly the cause of death. A tumor is not so often present, and when present is not so large as in cancer of the gall-bladder.—*Boston Med. and Surg. Jour.*, Dec. 5 and 12, 1889.

Debove on Cancer of the Stomach in a Boy of Eighteen.[1]—The subject of this observation, a boy of eighteen, having always enjoyed good health, was seized with profuse hematemesis, due, it was thought, to an ulcer of the stomach. On milk diet he improved much in appearance. Two months later a new hematemesis occurred, which was repeated and became incessant, producing an anæmia and rapid cachexia. Considerable ascites came on, and the patient died of syncope, three months from the first symptoms.

An autopsy revealed, on the lesser curvature of the stomach, but not invading that orifice, a flattish-shaped cancer the size of the hand and ulcerated on its surface.—*La France Méd.*, Nov. 30, 1889.

Hektoen (L.) on Simultaneous Perforation of Three Gastric Ulcers.—A young woman had complained of gastric pain, vomiting, and dyspepsia for years. While at work she was suddenly seized with excruciating abdominal pain, distension, and tenderness, and violent symptoms of general sepsis, of which she died in thirty-six hours.

At the autopsy there were found three oval perforated ulcers of the stomach, two near together on the anterior wall of the stomach near the greater curvature, and one directly opposite on the posterior wall. There was, of course, a diffuse purulent peritonitis present.—*Am. Practitioner*, Dec., 1889.

Vaillard and Chantemesse on the Rôle of Drinking-Water and Dust in the Propagation of Typhoid Fever.—The former observer has been able to isolate the bacillus of Eberth from water procured from certain wells to which were traced cases of typhoid fever. He is of the opinion that the germs of typhoid are also disseminated by dust from the ground or the floor.

Chantemesse reveals startling effects of contaminated drinking-water upon the health of Paris. Towards the close of October, because of a break in the aqueduct, the water of the Seine had to be substituted for that of the Vannes, and the city thus drank Seine water from October 31st to November 5th. The effect of this change of drinking-water is best mirrored by a glance at the records of admissions to the hospitals for typhoid fever.

From Oct. 27th to Nov. 2d, 56 admissions; from Nov. 3d to 9th, 40 admissions; from Nov. 10th to 16th, 95 admissions; from Nov. 17 to 23d, 77 admissions; from Nov. 24th to 30th, 185 admissions; and from Dec. 1st to 7th there were 186 admissions for typhoid fever.—*La France Méd.*, Dec. 24, 1889.

Dauchez (H.) on Infectious and Contagious Tonsillitis.—The author describes a peculiar affection of the tonsils which, by successively attacking different members of the same family or household,

[1] In a report of the same case in *La Tribune Méd.*, Nov. 28, 1889, the age of the boy is given as fourteen.—ED.

seemed to deserve the appellation of both an infectious and contagious disease. He has seen twenty-two cases in all. Chills, followed by a fever, sometimes very high, were prodromal symptoms, lasting from five to ten days. The tonsils then began to swell and to show creamy-white points, which remained visible from the first to the last of the acute attack—apparently miliary abscesses of the follicles of the tonsils. The disease is characterized also by the absence of enlarged glands, albuminuria, or paralysis.—*La France Méd.*, Dec. 7, 1889.

Crandall (R. P.) on Phthisis in Hayti.—The natives of Hayti believe phthisis pulmonalis to be both contagious and infectious, and fear it much more than yellow-fever or small-pox.

A native who is believed to be affected with this disease is avoided and shunned by all who know him, and becomes an object of prayer for the priests and of pity for the people.

When a consumptive dies, the entire contents of the room in which he died are either destroyed or thrown into some place set aside by the government for that purpose. This sacrifice of property not only includes the furniture of a room, but also articles of value, such as jewelry, gold, and precious stones. This idea of destruction is carried to such an extent by some, that the paper is sometimes removed from the walls and the floors torn up. Cases have even occurred where small houses, in which deaths from phthisis have taken place, were burned down to the ground to prevent the spread of disease.

While riding one day near the suburbs of Cape Haytien, the commercial capital of Northern Hayti, I came across a sort of marsh or land of mud known as the *Cimetière des Chevaux*. Scattered over its surface and half sunk in its muddy depths, were innumerable household articles, furniture of all kinds, sewing-machines, pianos, book-cases, books, etc. Here and there also appeared the whitened skeletons of animals.

My curiosity being excited, I asked of a native, standing near, the reason for this apparent waste of property. He informed me that the *Cimetière des Chevaux* was a repository for the dead bodies of animals, and for every thing that was found in the room of one who had died from *la poitrine* (consumption). When asked if any thing was ever removed from the cemetery, he answered that nothing would induce a Haytien to even touch any thing that had been placed there.

I found this to be strictly true, as on several occasions I offered natives sums of money to bring me articles from the cemetery, and was always refused with looks of horror and repugnance.

On careful investigation, I found that phthisis was regarded as contagious by all classes throughout Hayti.—*Med. Record*, Jan. 11, 1890.

Cornil on the Contagiousness of Tuberculosis.—In the course of some remarks on this subject this eminent authority states that tuberculosis was unknown in Terra del Fuego up to the time of invasion by the English. A missionary's wife, with pulmonary tuberculosis, founded a school to civilize the young savages, and instead succeeded in killing them. This epidemic of pulmonary tuberculosis, brought to Terra del Fuego by a missionary's wife, decimated the poor population. —*La Tribune Méd.*, Dec. 5, 1889.

Dubois (R.) on the Mechanism of Waking among Hibernating Animals.—The author has studied the habits of hibernating animals for two years, and of late has especially interested himself in trying to explain the mechanism of their waking. He discards several theories current at present, and favors a reflex irritation, starting from the ano-vesical region. He says reflex respiratory movements are much more marked when the deep parts of the recto-vesical region are excited. Moreover, he has noticed micturition always follows waking, and that the bladder, which gradually fills during sleep, is never evacuated except on waking. For these and other reasons he queries whether there does not exist between the recto-vesical reflex and the state of repletion of the bladder some relation which brings about, or at least favors, waking. In order to elucidate this question he formed a vesical fistula in two marmots, and, when they had recovered from the direct effects of the operation, he allowed them to go into the state of hibernation, which they readily did. Unlike other animals, they did not wake at the appropriate time, but slept right on, the sleep passing into death, with no sharp transition.

The author attributes death in these cases to the absence of the vesico-rectal reflex,

which resulted from the loss of urine as soon as secreted.—*L' Union Méd.*, Dec. 21, 1889.

Wells (E. F.) on Removal of Nerve-Pressure and Consequent Pain.—The author has noticed in women after delivery that a rapid subsidence of swelling in the lower extremities is apt to be accompanied by a severe pain in the same parts. He considers this pain due to a sudden relaxation of long-continued pressure on the nerves, and relieves it by constricting the legs or thighs with rubber bands in such a way as to allow only a gradual escape of œdematous fluid.—*Med. Standard*, Dec., 1889.

Luys and Bacchi on the Ophthalmoscopic Appearances in the Hypnotized.—In the state of catalepsy the observers noted a very marked hyperæmia of the papilla, the iris being greatly dilated and almost insensible to light. In the period of somnambulism much the same appearance of the fundus was present, but the color of the papilla was less intense, a less vivid red than in the cataleptic state. The iris, in the somnambulistic state, was more mobile and sensitive to light.—*Gaz. Hebd. des Sci. Méd., de Montpel.*, Nov. 30, 1889.

Cause of Death from Electric Discharge.—The deaths which have recently occurred in New York from electric discharge, and the post-mortem examinations made on those fatally stricken, have led to the conclusion that in the course of the electric current through the body the blood is the chief conductor. This is precisely what has been known in this country since the year 1869, when Dr. B. W. Richardson conducted his series of experiments on death by electric shock with the large electric coil set up by Mr. Apps at the Royal Polytechnic Institution. In those researches the experimenter, by passing electric currents of high tension through sets of glass tubes charged with different conducting animal substances, made the fact demonstrable that of all the animal structures blood was, preferentially, by far the best conductor. In the same researches it was also demonstrated (*a*) that discharges which by their intensity kill most rapidly leave least mark of distortion or of external injury; (*b*) that on complete prostration from the shock the heart may continue in action for several minutes after what appears to be actual death; (*c*) that the injuries inflicted on a living body by the shock are superficial burns and ecchymosed spots on the outer surface of the body, darkening of the color of the blood within the body, congestion of the heart and venous system generally, and injection, in some instances, of the mucous surface of the alimentary canal. The conclusion arrived at from these observations in regard to the cause of death from the electric shock was that the cause is a sudden expansion of the gases of the blood, with liberation of free gases from instant decomposition of the blood and the other fluids. Under the tension produced from the internal gaseous pressure, distension occurred in the venous canals, and the escape of bubbles of gas from the cavity of the cranium, on laying it open, was a frequent phenomenon. In one instance the right side of the heart of a sheep was ruptured from the cause named on the administration of the shock. But it was also observed in other instances that the whole of the discharge seemed to be conducted solely by the external surface of the body, under which condition there was extreme shock and prostration without death. It was this last observation that led Dr. Richardson to discard the idea of utilizing the electric shock for the painless extinction of the lives of the inferior animals, and to substitute the lethal chamber for that humane purpose.—*Lancet*, Dec. 21, 1889.

A Remarkable Suicide.—A remarkable case of self-inflicted death occurred in San Francisco, Wednesday, December 18th. A cook, while suffering from an intussusception, performed upon himself an abdominal section, and removed the strangulated and gangrenous intestine. Several days before, the man was admitted to the hospital complaining of an obscure pain in the bowels. His case seems not to have been diagnosed, and, after suffering two or three days, he informally took his departure. On the evening of the 17th he retired to his room with a companion and passed the night walking about the floor groaning in agony. At five in the morning the companion was aroused to see his friend standing nude in the middle of the room. A long incision had been made through the abdominal wall, the strangulated gut withdrawn and cut off. In doing this, several inches of healthy intestine were separated and some of the remainder mutilated. The man died in a few hours. Some ten inches of the bowel were telescoped, all of

which had become gangrenous. At the inquest a delicate question arose as to whether the jury should find a verdict of suicide or of accidental death. The man had killed himself, but he did so while in a delirium of pain trying to relieve his sufferings. The verdict, however, was suicide. —*Pacif. Med. Jour.*, Jan., 1890.

Burns (J. F.) on the Hour at which Death most Usually Occurs.—From a study of 15,000 cases, extending over a period of twelve years, it would appear that death occurs seemingly without any particular predilection for any certain hour, and that the number of deaths for each hour is very evenly proportioned considering the large number of cases taken and the time covered. The only very positive conclusions the author has formed from the figures are: 1—That the idea that more deaths take place in the early morning hours is an erroneous one. 2—If stimulants are to be pushed in disease during these hours, the practice must be justified upon some other ground than to avert the possibility of danger supposed to be very probable at this period. 3—That the vitality of an individual in disease is not regulated by the same influences or subject to the same laws that govern the vitality of a healthy human being, the normal equilibrium maintained in health between the mental and physical states being altered.—*N. Y. Med. Jour.*, Jan. 4, 1890.

REPORT ON OBSTETRICS AND DISEASES OF CHILDREN.

BY ELIZABETH STOW BROWN, M.D.

Lusk (W. T.) on a Case of Rupture of the Uterus and a Case of Cæsarian Section.—The first patient was a woman of thirty-three in her second pregnancy. The vaginal examination showed that no dilatation of the cervix had taken place, though the woman, when admitted to the hospital, had been in labor thirty hours. It was found that the non-dilatation of the cervix was due to firm, cicatricial tissue situated at the internal os and extending somewhat over the lower segment. The danger of rupture was regarded as immediate, as the uterine contractions were severe, and preparations were at once made for Cæsarian section. The woman begged to have the operation postponed a few hours, and her entreaties prevailed. Desiring to pass urine she began, in spite of all efforts to control her, to make violent straining efforts. Suddenly she fell back unconscious. Death followed in about two hours. On autopsy, it was found that the os externum was lacerated from her previous labor. The upper portion of the cervical canal was narrowed by dense cicatricial tissue, so that its diameter was about two centimetres. The antero-posterior diameter of the pelvis was ten centimetres; the transverse diameter, fourteen centimetres.

The rarity of the case consisted in the location of the cicatricial contraction, which was situated at the internal os and lower uterine segment. Dilatation by incision or other artificial means was impossible.

The rent in the uterus extended obliquely across the uterus from the upper cervical portion to the right side of the fundus. This furnished a new illustration of the fact that in spontaneous rupture the lacerated portion is not of necessity confined to the thinned lower uterine segment, as has been maintained by some of the extreme partisans of Bandl's theory.

The second case was that of a patient with kyphosis, pregnancy complicated with a pendulous abdomen, and Cæsarian section with fatal termination to mother, the child living.

The spinal deformity dated from a fall and serious injury in childhood. On admission to the hospital the patient was found to measure fifty-one inches. Owing to the extreme kyphosis, the three lower ribs overlapped the ilia. The space between the sternum and the symphysis was greatly diminished, so that the uterus in its development had been directed forward and outward. On admission, the fundus was four inches below the level of the pubic wall. For four months previous the patient had suffered constant pain in the back and on the left side. The indications for Cæsarian section resulted not so much from the pelvic contraction, though the outlet was greatly narrowed, as from the faulty position of the uterus, which directed the head backward and high up above the promontory. Rectification was rendered impossible by the nearness of the sternum to the symphysis. With the limited space, the elevation of the presenting part, and with the acute angle formed by the body of the uterus with the cervico-

vaginal canal, it seemed impossible to devise any plan of extraction by the natural passages which would not have subjected the utero-vaginal tissues to the certainty of fatal laceration. Consequently Cæsarian section was decided upon. The operation was purposely performed in a leisurely way. Owing to the small amount of abdominal space the uterus, soon after the removal of the child, subjected the abdominal stitches to a severe strain. For the first four days the patient did well. But on the fifth day she became restless, vomiting set in, tympanitis developed, temperature and pulse rose, and the patient died. At the autopsy, the condition of the uterus and its surroundings was good, but on removing the pelvis large abscesses were found, distending the sheaths of the psoas muscles, having their origin in carious bone at the site of the angle in the vertebral column. How far this condition was responsible for the fatal termination was a matter of conjecture.—*N. Y. Med. Jour.*, Sept. 14, 1889.

Kidd (F. W.)—Notes and Remarks on a Case of Complete Prolapse of the Cervical Zone of the Uterus Preceding Labor at Full Term.—The first patient had had three living children and five miscarriages before the pregnancy which led to the case in question. She never had any prolapse of the uterus, nor had she ever sought treatment for any uterine disorder.

In the ninth month she was attacked by pains like labor pains, and a "lump came down." The pains passed away and the tumor receded. In a few hours the pains returned and the tumor descended still lower. At intervals of several hours for three days the same pains recurred with lower and lower descent of the tumor till when she sent for the midwife it was "half way to her knees." The midwife thought at first that the tumor was the fœtal head with the membranes unruptured, but thought the membranes more red or raw-looking than any she had ever seen before. The patient was put to bed and the physician sent for; with decubitus the tumor went back very much. On examination the physician found a mass protruding for about three inches from the vulva. This mass was composed of the greatly congested and turgid cervical zone of the uterus, dragging down with it the vaginal walls. The os was in the centre of this mass and patent, so that he could easily introduce two fingers, but nothing could be felt except a soft membranous structure, which receded before his fingers as high up as he could reach. This canal seemed somewhat funnel-shaped, with the narrow apex below. The os internum was dilated. Grasping the cervical portion with his fingers, very much in the same manner as a paraphimosis is reduced, the author used some compression, and then slowly forced the prolapsed portion upwards, until it was in the normal position. Fearing lest labor should supervene whilst the cervix was still much congested, it was decided to perform version to make the breech the dilating part. Later, when the congestion was all gone, in the interests of the child, version (external) was again performed and the head brought down. The following day true labor pains came on, and the patient was delivered of a fine, strong male child, after a very short and perfectly painless labor. At no time during the labor did any prolapse of the cervical zone occur. Convalescence proceeded uninterruptedly.

The second case was of a primipara, a pale, fragile, deformed women of thirty-four. Her right knee was ankylosed, and the leg was at right angles to the thigh; the hip-joints were also affected by rheumatism. There was no deformity of the pelvis except that it was rather small. The patient had not been aware of any procidentia before labor came on. When the physician arrived the woman was having almost incessant pains, and she was forcing down as hard as she could, helping herself by pulling on a sheet tied to the top of the bed. The liquor amnii had drained away twelve hours before. On examination the head was found low down, distending the perineum well with each pain, but bringing with it the cervical zone of the uterus. This was dilated to about the size of a crown, and protruded from the vulva for about one inch or more. It seemed almost cartilaginous as to hardness, and about a quarter of an inch thick, fitting closely to the head; the scalp protruding about one inch in the form of a caput succedaneum. Fearing that there was danger of the uterus rupturing, so strong were the pains and so unyielding the cervix, chloroform was administered. The attempt was then made to dilate the cervix with the fingers. This proving ineffectual, it was determined to incise the cervix and apply the forceps. Four incisions, two anterior and two posterior, were made with a blunt-pointed bistoury

to the extent of about an inch from the margin. Short forceps were applied without difficulty, and a living female child was easily delivered. Convalescence was quite satisfactory. There was no hemorrhage from the incisions and no eversion of the cervical mucous membrane.

While this appeared to the author at the time to be a case of extremely rigid os, later it seemed just possible that it might have been a case of hypertrophy and elongation of the cervix, if it could be believed that it could have existed to some considerable extent without the patient's knowledge. In two months after labor there was not a trace of hypertrophy of the cervix.—*The Dublin Jour. of Med. Sc.*, Jan. 1, 1890.

Landberg (K.) on Manual Treatment of the Pregnant Uterus.—The author, having for some years practised the manual treatment in proper cases of pelvic diseases of non-pregnant women, has tried the method on the pregnant uterus. The results have been so gratifying that he feels that it can be recommended to the profession. But with the recommendation a warning is added. There is no doubt that this treatment carelessly given is capable of causing interruption of the pregnancy, while properly given it is a great means of preventing abortion. While some pregnant uteri can be handled almost roughly with impunity, others are very sensitive and respond to a not very severe treatment with so strong contractions that, if the treatment is not interrupted or given very lightly, expulsion of the ovum will follow. For this reason it is necessary always to begin the treatment very cautiously, and if at any time the patient complains of pains like labor-pains, or if the uterus can be felt during the *séance* to contract in any way forcibly, the treatment must either be interrupted or given very lightly.

The author gives the history of six cases where repeated miscarriages had occurred, and where the last pregnancy had with the aid of massage been successfully carried through. Of the six cases, three were cases of retroflexion, two of extensive laceration of the cervix, and the sixth a case of prolapsus uteri gravidi, fourth or fifth month.

As to the execution of the method, each case may require modification in it. The *froppement* of the lumbo-sacral region, supposed to cause contraction of the uterine ligaments, the author has used in some of these cases, in others not. In manual massage, all the work is done by the outside hand through the abdominal wall; the one or two fingers of the other hand in the vagina serve different purposes, lift the uterus up, press the cervix back or make counter-pressure against the outside hand. Its principal object is, however, to serve as an indicator of what the outside hand is doing. As to the motions of the outside hand, these follow the same rules as for massage in general, always to follow the venous circulation. In these cases, that will be from the fundus uteri down towards the internal os, and on the cervix up towards the internal os; from the internal os out to the side of the pelvis, and then backwards and upwards towards the sacro-iliac joint

The objects and effects of the treatment are:

1. To place the uterus and its appendages in a normal position.
2. To empty over-distended sinus and accelerate sluggish circulation.
3. To remove all inflammatory products in the uterus itself or in the pelvis.
4. To stimulate over-distended ligaments to contraction, and to remove obstacles in this direction; for example, by stretching a shortened opposite ligament, or by holding the uterus for a while in a position favorable for the contraction of some ligament at the same time, while stimulation is effected by massage movements of the other hand.—*N. A. Pract.*, Dec., 1889.

Chapin (H. D.) on the Auriculo-ventricular (Presystolic) Sound; Some Considerations on Cardiac Disease in Early Life.—A presystolic or auriculo-ventricular sound is produced by some interference with the normal and easy passage of blood through the auriculo-ventricular septum or valve. The murmur is rough in quality, beginning at the end of diastole and ending abruptly with the systole. In rhythm it may hence be considered post-diastolic as well as presystolic. One of the most characteristic points about this murmur is its abrupt termination. The quick stop of the abnormal bruit is very different from the gradual ending of mitral regurgitation. The presystolic murmur is generally considered to be due to organic disease at the mitral valve. There is a class of cases, however, in which the author has heard the murmur distinctly, which he

believes to be entirely free from organic heart-disease. Reference is here made to growing children, especially girls, who are pale and hydræmic, and suffer from various digestive troubles. These cases are not only subject to palpitation of the heart, but, at times, especially after exercise, a more or less rough presystolic murmur may be heard at the apex. Many of these children have been confined for a long time in crowded or badly ventilated school-rooms. Possibly they are over-ambitious in their studies, but, at any rate, are in a condition of defective nervous equilibrium. Under treatment by iron, cod-liver oil, nutritious and easily digested food, with plenty of fresh air, the abnormal heart-sound will often disappear. It has seemed to the author that the trouble in these cases is due to an irregular muscular action, dependent upon a defective innervation of the heart. Weak children have an especial tendency to a faulty, over-irritable action of the muscles, both voluntary and involuntary. This may be shown only by incontinence of urine, or by twitching of certain muscles of the face; or it may eventuate in general chorea. In such a case an irritable, strongly acting auricle, with a mitral valve whose muscular fasciculi are too tense, might be a cause of a blubbering sound just before the systole. The sound produced by any such irregular muscular action would be intensified by the watery condition of the blood. Undoubtedly a large proportion of cases of the presystolic murmur are due to organic valvular trouble. The histories of forty cases are presented, which have been kept under observation for different intervals of time, varying from a few weeks to several years. The youngest case was two years old; one was at seven, four at eight, four at nine, two at ten, five at eleven, four at twelve, four at thirteen, six at fourteen, two at fifteen, two at sixteen, and five at later periods of life. The connection with rheumatism is an interesting consideration. Out of thirty-one cases of mitral obstruction, twenty presented evidences of rheumatic taint. In making a diagnosis of the mitral direct murmur, it is to be remembered that it varies according to the action of the heart.

It is frequently the experience of physicians to be called upon to treat cases of valvular disease which cannot be traced back to their inception. The author believes that a large proportion of the valvular diseases in the adult have begun in childhood. The nature of the rheumatism which attacks children is obscure and often overlooked. The perfect compensation usually occurring in childhood prevents many of the symptoms of circulatory disturbance seen in later life. Their vascular system is likewise healthy and elastic, which facilitates the work of the heart. In many of these cases, however, there is a faulty nutrition, with more or less profound anæmia. If there is no hypertrophy of the left ventricle, it is not probable that any serious valvular defect is present.—*N. Y. Med. Record*, Jan. 4, 1890.

Holt (L. E.) on the Classification and Nomenclature of Diarrhœal Diseases of Infancy from a Study of the Lesions.—With the end in view of aiming at a philosophical classification of the intestinal disorders of infancy, the author began several years ago a series of operations upon the pathological anatomy of the diarrhœal diseases in young children, some of the results of which are here presented. Microscopical examinations have been made in this connection upon the intestines of one hundred and nine cases. Seventy of this number died of diarrhœal disease or complication. The scheme of classification is made up chiefly from a study of the clinical and pathological features of these seventy cases, but modified by a comparison of upwards of fifteen hundred non-fatal cases of diarrhœa among children. A classification based solely upon the pathological findings becomes complicated and needlessly confusing to the clinician. This difficulty the author has tried to meet by placing in the left-hand column the best grouping of the cases clinically which he could make, and to show the relation of these to the pathological conditions, which are arranged in the right-hand column.

Clinical.	*Pathological.*
I. Simple diarrhœa	No lesions.
II. Acute mycotic diarrhœa 1. Acute dyspepsia. 2. Cholera infantum.	Acute desquamative catarrh.
III. Acute entero-colitis	1. Catarrhal. 2. Croupous. 3. Follicular ulceration (ulceration of lymph nodules.)
IV. Chronic dyspeptic diarrhœa	Hyperplasia of lymph nodules, or no lesions.
V. Chronic entero-colitis.	1. Chronic catarrhal inflammation. 2. Follicular ulceration.

—*N. Y. Med. Jour.*, Jan. 18, 1890.

Vaccination of New-Born Infants.—At a recent meeting of the Medical Society of

Berlin, Mr. Max Wolff discussed the question of the vaccination of new-born infants. After a very extensive experience he denies that any danger attends the vaccination of very young children, if properly and carefully carried out. He showed that the generally received opinion that newly-born infants are refractory to vaccination is founded on error, arising from the fact that in these subjects the subcutaneous fatty tissue is very scanty and the skin mobile, so that incisions are required, and not simple pricks. He made five different series of observations. In the first he vaccinated eight newly born infants with human lymph, and all proved successful. In the second series he vaccinated twenty pregnant women, and later on their offspring, between the first and the sixth day after birth. In every case the result was successful. Finally, he vaccinated fifteen infants somewhat older than the preceding instances, using calf lymph. The result was the same, but the constitutional disturbance was more marked. The question of immunity is not easy to establish with scientific accuracy, but at the Foundling Hospital at Moscow, out of 34,677 newly born infants who were vaccinated, only a very small proportion subsequently contracted small-pox or proved susceptible to the effects of revaccination. —*The Med. Press*, June 12, 1889.

Charpentier and Butte on the Influence of Maternal Hemorrhages on the Vitality of the Fœtus.—The researches of these observers, experimental in character, were conducted on rabbits near the end of pregnancy. They demonstrated that hemorrhages, sufficiently rapid and profound to kill the mother, do not kill the fœtus if immediately extracted. If the hemorrhage is slow and yet sufficient to finally kill the mother, the fœtus dies, generally before the mother. Finally, if the hemorrhage, although free, is not enough to kill the mother, the fœtus generally dies about an hour after the commencement of the hemorrhage. The death of the fœtus before the mother is explained by the diminution of oxyhæmoglobin in the maternal circulation, and also by the diminution of blood-pressure. The authors conclude from their experiments that, in all cases of grave hemorrhage in advanced pregnancy, labor should be speedily brought on to save the fœtal life.—*Gaz. Hebd. des. Sci. Méd. de Montpellier*, Nov. 30, 1889. R. W. A.

Leonard (T. K.) on an Unusual Case of Obstetrics. — A woman gave birth to a male child on the 26th of November, 1888. Nothing unusual occurred in the time of an ordinary labor, but she was safely delivered, and the placenta came away in due time, but not a drop of blood escaped, either before or after the birth of the child, or after the expulsion of the placenta; nor was there any blood, or even colored fluid, which passed away at any time, but a free discharge of colorless watery fluid.

The patient has now the appearance of being nearly exsanguine, and, from her history, has always been in remarkably feeble health.

The little boy, though feeble for a considerable time, is now doing well, and growing finely.—*Atlanta Med. and Surg. Jour.*, Jan., 1890. R. W. A.

REPORT ON DISEASES OF WOMEN.

BY JOHN S. HAWLEY, M.D.

M'Mordie on the Effects of the Electric Current when Applied to the Pelvic Organs of the Female.—The facts adduced and proved by Apostoli and others are very few, and any ascertained effect of the electric current which has been passed through any organ, whether it be in physical change or physiological action, is worthy of a place in the records. The author has made experiments as to the effect produced by the continuous current from a one-cell battery on uterine hemorrhage, one pole being attached to an intra-uterine electrode, and the other to a flat conducting plate placed over the fundus. When the current had been passed for from ten to twenty minutes, two effects were produced. The os externum, if small, became dilated, and in many cases in which the females were healthy the sexual orgasm was induced. The current had no effect upon the hemorrhage. The author believed that the electric current had been accredited with the power to promote the extrusion of intra-uterine fibroid tumors in cases in which such result was simply a coincidence, and cites that of one of his own patients, who had had a tumor for two years. One might easily mistake this for a fibroid, although it proved to be a mass of

fæces. Had electricity been employed under the impression that a fibroid existed, the subsequent disappearance of the mass might have been ascribed to its use. Only the experience of many years will enable one to form a sound opinion as to the real value of Apostoli's method of treatment of fibroid tumors.—*Brit. Med. Jour.*, Dec. 14, 1889.

Recurrent Intra-Abdominal Hemorrhage after Laparotomy.—Kustner records an interesting case of a woman in whom, after laparotomy, recurrent intraperitoneal hemorrhage occurred. The patient was fifty years of age, and the operation became necessary in consequence of carcinoma of the ovary. The operation was unattended with incident beyond the occurrence of vomiting, which did not prove troublesome. Four hours and a half after the patient had been removed to bed, signs of internal hemorrhage supervened. The author reopened the abdominal cavity, and found it full of blood. All the latter was cleaned out, the pedicle secured with a clamp, new sutures and new dressings applied. The procedure was apparently successful. The patient, however, after the lapse of another hour, was again discovered to be in an almost moribund condition. A litre of chloride of sodium solution was injected into the right median cephalic vein. The result was at first satisfactory; soon, however, the signs of hemorrhage again occurred. The abdomen was opened for the third time, the cavity washed out, and a litre and a half of the solution above-mentioned poured in, and the wound closed. The patient gradually recovered. There was no rise of temperature. The sutures were removed on the eleventh day, and convalescence was complete on the twenty-second.—*Med. Press*, Dec. 10, 1889.

Stark (J. N.) on Some Less Common Causes of Menorrhagia.—The author relates the histories of several cases in which menorrhagia was the prominent symptom, but in which there was to be found no adequate cause in the pelvis, the organs therein contained being apparently healthy. The hemorrhage was found to be due to conditions existing in other organs, which induced passive hyperæmia of the pelvic organs, and consequent uterine hemorrhage; mitral stenosis resulting from rheumatism, hepatic congestion and gastritis from alcoholism. Constipation and the effects of tight lacing are the causes mentioned, relief following treatment directed toward these conditions.—*Glasgow Med. Jour.*, Jan., 1890.

Creolin in Gynecology.—Extensive experiments have been made by Chéron with creolin in two- and five-per-cent. solutions. The weaker solution was used for vesical injections in cases of gonorrhœa. Neither poisoning nor pain resulted; the discharge from the urethra diminished and soon disappeared, injections being made every other day. Gonorrhœal vaginitis was quickly improved by irrigation of the vagina and vulva with the five-per-cent. solution. In purulent cervical endometritis, the diseased tissues were first carefully cleansed with absorbent cotton, after which an application of the five-per-cent. solution was made. After a few applications the suppuration ceased. Creolin gauze was found to be an excellent substitute for iodoform gauze in cases of suppurative and hemorrhagic endometritis in which a tampon was required. From the foregoing it was concluded that creolin has a very positive effect upon the microbes of gonorrhœa and of pus, and that in ordinary doses it is neither painful nor toxic.—Translated from *El Prog. Gin.*, May 10, 1889, in *Annals of Gynæcol.*, Dec., 1889.

Doran (A.) on Closure of the Ostium in Inflammation and Allied Diseases of the Fallopian Tube.—The author dwells on the frequency of closure of the ostium in salpingitis; but the obstruction is often temporary. Obstruction of the uterine end is due to swelling of the mucous membrane or to the development of "Chiari's bodies" from that membrane. Permanent closure of the tube is almost synonymous with closure of the ostium. Salpingitis and perimetritis are the causes of closure of the ostium. Three essential factors in relation the subject are considered at length: (1) the nature of the ostium and its fimbriæ; (2) the nature and varieties of salpingitis, and also of perimetritis as far as it affected the tube; (3) the precise manner in which the ostium was closed in perimetritis and salpingitis. In adhesive perimetritis the fimbriæ of the tube are bound down by bands, which thus obstruct the ostium. In salpingitis the ostium is obstructed, incompletely at first, by the swelling of the mucous membrane which involves the fimbriæ, but permanently in bad cases by great infiltration of

the submucous tissue and middle coat, which swell over the ostium and cover in the fimbriæ. The question of timely conservative operations on obstructed non-suppurating tubes is discussed. Dr. Skutsch's "salpingostomy," where a small piece of the tube was excised, appears to be a promising step in that direction.—*Br. Med. Jour.*, Dec. 14, 1889.

A Case of Subperitoneal Myofibroma of the Uterus.—Dr. Guisani showed naked-eye and microscopic specimens of a uterine tumor which he had removed by abdominal section. The patient, aged forty-five, unmarried, had a history of prolonged dysmenorrhœa and gradual enlargement of the lower region of the abdomen. The nature of the tumor having been diagnosticated, it was removed, and the pedicle (an unusually long one) ligatured in halves, with the precaution of a second ligature placed nearer the uterus. The wound was dressed, closed, and the pedicle enclosed in the cavity. Drainage was effected by a tube in Douglas' *cul-de-sac*. An antiseptic dressing of sal-alembroth gauze was applied over the abdominal incision. The general treatment consisted of iced water for the first six hours, and next day milk, aqua calcis, and hot water to relieve flatus. Broths, etc., were administered from the third day, the patient making an uninterrupted recovery.—*Br. Med. Jour.*, Dec. 21, 1889.

Sutton and Brodie on Adenoma of the Cervix Uteri in Monkeys.—The authors have for some time been engaged in investigations relating to the existence of uterine cancer in the lower animals, and had met with a case of metrorrhagia and leucorrhœa in a monkey,—a macaque,—of which the uterus was found to be retroflexed, and with a florid mass projecting from the os, resembling closely what is termed an erosion by gynæcologists, and presenting under the microscope the characters of cervical adenoma as seen in the human female. They had detected exactly analogous conditions, in so far as some of the appearances were concerned, in erosions of the human cervix and in a case of cancer of the cervix.—*Lancet*, Dec. 7, 1889.

Jackson (R.) on the Choice of Methods in the Treatment of Uterine Cancer.—The author, having considered the relations which each of the three prominent methods of dealing with cancer of the uterus sustains to the questions of immediate mortality and remote results, thus fixes their status.

Partial amputation is doubtless a beneficial procedure. With a low rate of mortality, probably not exceeding five or six per cent., it has in many cases removed the disease permanently, and in others stayed its progress and prolonged life.

In a still greater degree actual cauterization has been shown to be potent for good. The recently published results obtained by Dr. Byrne are wholly without parallel, both in the extremely low death-rate and the greatly prolonged immunity from disease. Dr. Byrne's report is unquestionably by far the most favorable showing that has ever been made concerning any method of treatment for uterine cancer in any considerable number of cases; and as such it distinctly challenges our consideration.

Hysterectomy is a ghastly failure. Not only has it given worse results, both immediate and remote, than other methods of treatment for cancer of the uterus, but it is worse than no treatment at all. A hundred women with uterine cancer will live a greater aggregate of years if left alone than if subjected to hysterectomy.—*Med. News*, Jan. 18, 1890.

Parish (W.) on the Treatment of Pelvic Abscess in the Female.—The author strongly urges the necessity of operating early in every variety of curable pelvic abscess.

The besetting sin of the family practitioner and of the timid and doubting operator is to wait. In this delay the dangers become cumulative, and the surgeon is asked to operate when the case is hopeless. If the patient dies the general practitioner often is discouraged, and in his next case he waits still longer, under the hope that pus may not form, or that it may escape spontaneously. He has seen some instances in which he believed suppuration had occurred, and yet resolution took place, and he has seen other instances in which, after spontaneous evacuation, recovery was rapid. So he justifies his delay, and gynæcology receives the unmerited obloquy attendant upon fatal results, inas much as the conditions under which an operation is performed are rarely considered by the public or by the profession.

The formation of permanent fistulæ is usually an evidence of the lack of skill or courage on the part of the physician. The

fistulous tracts constitute, it may be, indelible evidences of cowardice and inefficiency on the part of the medical attendant. Early surgical interference with the knife should be the inflexible rule in the treatment of all varieties of pelvic abscess.—*Med. News*, Jan. 18, 1890.

Massey (G. B.) on "Menorrhalgia and Menorrhspasm."—The author objects to the term "dysmenorrhœa" as suggesting only the mechanical form of painful menstruation, and in its place suggests the adoption of the word "menorrhalgia" as etymologically more significant as well as more in accord with associated terms. When this condition is due to an inhibitory spasm, the term to be employed is "menorrhspasm." He finds both the theory of obstruction of the cervical canal from flexion or stenosis as a cause of painful menstruation and that of parametris as the true etiology to be unsatisfactory, since there is an abundance of clinical evidence diametrically opposed to that on which both theories are founded; and calls attention to the influence of hyperæsthesia of the endometrium and of spasm—not due to the presence of pent-up fluid, but actually preventing the normal exudation of the menstrual discharge, and due to other than mechanical causes—as the great factors in the etiology of painful menstruation. In his own words: "Menorrhspasm, in brief, may be said to be a neuro-myotic storm of the uterine neuro-muscular apparatus, which renders the excretion of the menstrual fluid temporarily impossible. Its remote causes may be traced to all those influences in modern life which hinder the proper development of animal life in young women. This menorrhspasm is usually accompanied by a permanently hyperæsthetic condition of the endometrium, and is often indicated between periods by a spasmodic stricture of the internal os when an attempt at sounding is made. Exactly how much of this intermenstrual stenosis is spasmodic, and how much fibrous, remains to be proven. The existence of the fibrous variety is, of course, undoubted." Like pathological anteflexion and chronic metritis associated with menstrual pain, it bears no *essential* causal relation to the symptomatic pain, as equally marked abnormalities of structure and condition of the uterus are often unaccompanied by menorrhalgia.

The treatment is general and local, the former being directed towards the improvement of the hygienic condition of the patient, and the latter, négative intrauterine galvanization, with a current intensity of from 15 to 50 milliampères. Divulsion of the cervical canal does cure some cases, probably by paralyzing the irritable nerve-fibres; but it fails to give relief in a large number of cases. The galvanic current is less severe and much more effective.—*Maryland Med. Jour.*, Jan. 11, 1890.

Taylor (R. W.) on Chronic Inflammation, Infiltration, and Ulceration of the Vulva.—The author, in treating of all non-malignant, hypertrophic, ulcerative vulvar lesions, emphatically denies the existence of such an entity as the esthiomène of Huguier, and offers the following conclusions concerning the nature of the condition falsely so-called, or practically so regarded by most as lupus:

1. That a large, and perhaps the greater, number of chronic deforming vulvar affections are due to simple hyperplasia of the tissues, induced by irritating causes, inflammation, and traumatisms.

2. That chronic chancroid is a cause in a certain proportion of cases.

3. That many cases are due to essential and specific syphilitic infiltrations.

4. That other cases are caused by the hard œdema which often complicates and surrounds the initial sclerosis and perhaps gummatous infiltration.

5. That many cases are due to simple hyperplasia in old syphilitic subjects, who suffer from chronic ulcerations of the vulva long after all specific lesions have departed.

6. That some cases also in old syphilitics are due to simple hyperplasia, without the existence of any concomitant ulcerative or infiltrative process, and seem to be caused by conditions which usually in healthy persons only result in vulvar inflammation.—*N. Y. Med. Jour.*, Jan. 4, 1890.

[We regret that lack of space forbids a complete abstract of this scholarly and exhaustive paper, as it deserves much more attention than can be given to it without exceeding the scope of this report. It should be carefully read by every one who attends to gynæcological work to any extent, and it will amply repay such a one for the time he may expend in its perusal. —J. S. H.]

Byford (H. T.) on Inguinal Suspension of the Bladder as a Cure for Cystocele.—The author has devised and

performed an operation for the relief of those cases in which the ordinary plastic operations on the vaginal walls fail to prevent the subsequent protrusion of the cystocele, and offers it as a procedure which should be supplemented by the plastic operations for the restoration of the pelvic floor. The operation—which he christens "colpo-cystorrhaphy"—is performed by cutting into and through the posterior wall of the vaginal canal into the post-pubic cellular tissue; this is then separated from the pubes, and, after locating the ureter, a needle armed with a silkworm-gut suture is passed through into the vagina at the sulcus, and back again into the external wound from the vagina, at a point about ¼ inch from the puncture of entrance, so that a portion of the vaginal wall is included in the loop of the suture, the ends of which emerge from the incised inguinal canal. A second suture is passed deeply into the cellular tissue from side to side; both sutures are then drawn tightly and tied in the canal in such a way as to close the incision in its posterior wall. The anterior vaginal wall is thus drawn half-way up the posterior surface of the body of the pubes. If necessary, the same procedure is employed on the other side, colpo-perinæorrhaphy is performed, and the necessary after-treatment carried out.—*Am. Jour. Obstet.*, Feb., 1890.

The Treatment of Chlorosis.—The attention of physicians has been almost exclusively centred upon the medicinal treatment of chlorosis, the hygienic management of this disorder of nutrition being, as a rule, altogether overlooked.

These remarks have been suggested by the report of a number of well-marked cases of chlorosis successfully treated by enemata of defibrinated blood. M. Antiq (*Lyon Médicale*, No. 44, 1889), the originator of this method, claims remarkable success from its employment, and believes that it fulfils, more successfully than any other, the three indications in the treatment of chlorosis, namely: 1. Restoration of iron. 2. Restoration of oxygen. 3. Restoration of the salts of potash and of the chlorides.

With no intention of discrediting these observations, we venture the prediction that this somewhat *outré* method of treatment will be found of limited application, for, like the ordinary mode of administering iron, it is, so to speak, too direct.

The greatest success in the treatment of chlorosis will be achieved by those who bear in mind that, whatever the predisposing cause of this nutritive disorder may be, its exciting cause may vary in each individual. Each case, therefore, must be treated on its own merits. Of general application are hygienic measures, such as out-door exercise on foot, on horseback, sea-bathing, massage, etc.

When it is recalled that the merest trace of iron which is present in mothers' milk is sufficient to supply the wants of a rapidly growing organism, it becomes evident that the cause of chlorosis is something which interferes with the assimilation of that metal. Iron is found, by experience, to be necessary in all cases, but it is useless in many unless combined with the general hygienic measures to which allusion has been made.—*Med. News* (Editorial), Jan. 25, 1890.

REPORT ON INSANITY AND NERVOUS DISEASES.

BY FREDERICK PETERSON, M.D.

Cameron (I. H.) on a case of Punctured Fracture of Skull; Aphasia; Trephining and Recovery.—A. P., aged eleven, was struck on the head, November 25th, with a rake by another boy. Dr. Cameron saw the boy two days later. There was a wound as large as a sixpence near the left parietal eminence, from which thick pus was oozing. The edges were swollen and baggy. No palsy; eyes parallel, pupils equal, tongue straight. He could answer "yes" and "no" appropriately, but when asked to repeat anything else would say only, "ah-ah-ah-yes," and would reiterate this over and over again. He could count fingers from one to five. When asked how many fingers there were on both hands, he insisted that there were eleven. When asked how many five plus five made, he replied nine, but subsequently said ten. Since his recovery he makes such simple calculations accurately. Temperature 100.2°; pulse 60. Aphasic symptoms disappeared on the second day after the accident. Admitted to hospital November 29th. Condition unchanged, except that he was somnolent. Would lie quiet unless disturbed. He was trephined November 30th, and a ragged puncture of the skull was found, with pus and a piece of black cloth one quarter inch square in it.

The dura was lacerated, but healthy-looking.

He complained of headache occasionally after the operation, his temperature at such times invariably falling to 97°, or even to 96°. In the third week after the trephination, he became unable to open his mouth, except to a very limited extent, and during his efforts to do so his chin became deflected to the left. This lasted three or four days, and then passed away. The aphasic symptoms gradually passed away. The centre of the wound was midway between the tip of the mastoid process and the sagittal suture, three and one half inches from each point. It was one and three quarters inches behind a line drawn vertically through the external auditory meatus. Hence the superficial wound seemed to lie just over the cortical area lying about the posterior extremity of the horizontal limb of the fissure of Sylvius. Pressure was exerted by the depressed fracture probably over parts of the angular gyrus, supra-marginal gyrus, and posterior part of first temporal.

The case was regarded as one of conduction-aphasia, and it was supposed that the prong of the rake penetrated sufficiently far to injure the conduction between the motor and auditory speech-centres.—*Canadian Pract.*, Jan. 1, 1890.

Glynn on a Case of Word-Blindness.—Dr. Glynn, senior physician to the Royal Infirmary, has recently had a case of mind-blindness under his care. The patient, a man of middle age, fell from a height and sustained a fracture of the skull in the occipital region. Soon after the accident his visual perception centres were involved, to the extent that he was unable to distinguish the characters and uses of the objects about him. He was in no way paralyzed, but he had lost all skill with his tools, and had to a great extent forgotten their names and uses. On trying to sew a piece of leather—part of his usual occupation—he went hopelessly wrong, did not see that he was blundering, and refused to be put right. When he came under Dr. Glynn's care the mind-blindness was confined to the inability to recognize written and printed words, and to some extent single letters. Other objects and persons he recognized without difficulty. He had no motor aphasia nor word-deafness, and he was able to write quite readily, but after writing his name he was immediately unable to read it. If, however, his forefinger was made to trace the letters he was able to name the word, and he sometimes succeeded in reading by forming the letters in the air. The patient also had right hemianopia in the right eye, with concentric constriction of the field of vision, and in the left eye vision was restricted to the region around the yellow spot. There was a depression of bone over the occipital lobes, which was raised by Mr. Reginald Harrison. The patient left the hospital soon after the operation, before any careful observations of its results could be made, but it was definitely ascertained that the field of vision was increased. Dr. Glynn is of opinion that the lesion causing mind-blindness was in this and similar cases situated in the occipital lobes, disease of which also causes homonymous hemianopia. He thinks that cases in which mind-blindness had been attributed solely to lesion of the angular gyrus may be reconciled with this view on the supposition either that a coexistent lesion of the occipital lobe has been overlooked, or that the lesion of the angular gyrus was sufficiently deep to implicate the fibres proceeding from the occipital lobe. On any supposition it is difficult to explain in the present case the almost total amblyopia of the left eye, unless we suppose in the right hemisphere the presence of a lesion causing crossed amblyopia, and in the left one causing homonymous hemianopia. This supposition would afford a simple explanation of the case if the patient had been left-handed, but such was not the case.—Liverpool Corr. *Brit. Med. Jour.*, Jan. 4. 1890.

Tuke (J. B.) on the Surgical Treatment of Intracranial Fluid Pressure.—In a typical case of general paresis, Mr. John Duncan, at the request of the author, removed, by trephining, a considerable amount of the calvarium above and in front of each parietal eminence. The bone was found thick, and on its removal the dura mater bulged into the wound, but was not opened. The bone was not replaced. The wound was practically healed in twenty-four hours.

On recovery from the chloroform no change in the inequality of the pupils was noted, but on the following morning they were almost equal, and reacted better to light than previously; this continued for five days. The most obvious result was the change in the mental condition of the

patient; his intellect was distinctly clearer; for the first time since admission he recognized the fact that he was in a hospital, his manner was calmer, and he was evidently more sane than he had previously been. He ceased to have hallucinations, asked for what he wanted in a rational manner, and the headache disappeared. This improvement, however, only lasted for five days, when the old symptoms returned, with the exception of headache. The patient, seen lately, was much demented, with ataxic symptoms very well marked. He is showing progressive symptoms of a downward tendency. The scalp is drawn inwards in the trephine holes; pulsation is not to be felt on pressing the fingers into either of them.—*Br. Med. Jour.*, Jan. 4, 1890. R. W. A.

Toll (H.) on Operation under Hypnotism.—A. S., male, aged seventeen, entered St. Barnabas Hospital, Minneapolis, September 8th, with osteomyelitis of humerus. There was considerable pain, redness, and swelling, partial immobility of elbow and shoulder joints, and three fistular openings (one into axilla, one above deltoid insertion, and one higher up and farther back than the latter). Dr. Toll hypnotized the patient six times during the three days preceding the operation in order to obtain good control.

On September 9th he was hypnotized in his bed and then led to the operating table. The three fistulæ were explored, scraped, and washed out, after which an incision four inches long was made on the outer aspect of the upper third of the arm down to the bone, and an opening three inches long and three fourths of an inch wide chiselled down to the medullary canal. The patient was cataleptic, and would turn from side to side, move about, or sit up as directed during the operation. About ten o'clock he was taken back to his bed, and the suggestion made that he should waken at noon and have something to eat.

At twelve o'clock sharp he sat up in bed and said: "Dr. Toll said I could have something to eat at twelve o'clock."—*Med. Record* (Corr.), Jan. 4, 1890.

Bertrand (J. H.) on Potassium Iodide for Headache.—The author gave this drug in twenty unselected cases of headache. In four cases it did no good. In two it afforded some relief. In two others it caused transient cessation of the pain. In the remaining twelve cases it gave complete permanent relief. Six grains are dissolved in two ounces of water, and a teaspoonful of this given every few minutes until relief is obtained, which is usually in from fifteen to forty-five minutes.—Central Wis. Med. Assn. Trans. quoted in *Med. Standard*, Dec., 1889.

Leslie (G.) on the Cure of Facial Neuralgia, Odontalgia, etc., by the Insufflation of Chloride of Sodium into the Nose.—The author gives an account of twenty cases of neuroses, mostly of the branches of the fifth nerve, treated and cured by the novel method which he describes as follows:

On the 16th of August, 1889, I found that, by an operation of extreme simplicity, I was able to arrest a very severe attack of supra-orbital neuralgia, and in what seemed to be no more than the period of nerve transmission. The idea at once suggested itself, that if a neuralgia or other pathological condition of one branch of the fifth cranial nerve could be controlled so easily, it was almost certain that similar conditions of other branches of the fifth, and probably of other cranial nerves, might be successfully treated by the same means. I immediately began a research on this point, which has been carried on during the past three months, and of which I now beg to lay the results before you. They appear to be important—to show, indeed, that many of the most distressing and acutely painful ailments to which we have been supposed to be heirs—such as neuralgic headache, faceache, toothache, earache, and allied complaints—are, in the great majority of cases, unnecessary, and that a beneficent Nature has provided for them, to the rich and poor alike, an effectual remedy.

For all the cases of this nature which have come under my care a uniform treatment has been followed. It has been the application of powdered chloride of sodium—common table salt—to the nasal mucous membrane. The salt may be used by the patient as snuff, a pinch being taken into the nostril of the affected side, and in many cases I have found this to be effectual in preventing recurrence, but the best results have been got when the salt has been applied by means of an insufflator. In practice I charge a small insufflator, the chamber of which contains about four grains, and ask the patient to draw air up

the nostril while I inject the contents. It will be found that the application produces little pain or discomfort.

It is probable that other chemical substances, especially those allied in constitution to chloride of sodium, may produce similar therapeutic effects, but as I have not had a specially obstinate case in my own practice, I have not yet tried others, and have considered their discovery a matter more of scientific curiosity than of practical importance. The stimulation by chloride of sodium appears to induce in the nasal branches of the fifth nerve a form of nerve motion, which causes reflex inhibition of the pathological process in the nerves affected, inhibits the abnormal form of nerve energy, of which the expression is pain, and replaces it by the normal form, of which the expression is not pain.

The mode of disappearance of the neuralgia is noteworthy. So unattended is it by any form of shock or other unpleasantness, that though the patient may be suffering from intense pain one minute, and be absolutely free from it the next, it is generally somewhat longer before he can realize his altered condition, and he usually employs a short time in introspection before announcing the favorable result.—*Edinburgh Med. Jour.*, Jan., 1890.

Van Gieson (I.) on the Pathology of Tabetic Crises.—The author described in detail a case of tabes with laryngeal attacks during the last year of the illness. One of the crises proved fatal. Microscopical examination showed the lesions of a chronic neuritis of the roots of the vagus and accessory portion of the spinal-accessory nerves on both sides. Neuritis of the root-fascicles or trunks of one or both of these was regarded as more frequently the cause of the laryngeal crises than central lesions.

The author divided laryngeal crises into two classes: A first class in which the glottis constrictors and dilators were normal, and the crises occurred by reflex spasm of the adductors; a second more numerous class of cases, in which the constrictors and dilators are in a greater or less degree of paralysis.

The first form of the crisis might be produced by a neuritis of the roots of the accessory portion of the eleventh nerve, irritating the sensory fibres of the larynx, and being responded to by motor impulses through the vagus, which would produce closure of the glottis by contraction of the adductors. The second form of the crisis might be produced by a destructive stage of the neuritis in the vagus, inducing a motor inability of both the adductors and abductors. But as it has been shown experimentally in animals that the adductors are stronger than the abductors, a reduction of power in both sets of muscles would render the equilibrium of the two sets of muscles so unstable that reflex irritation of the motor laryngeal fibres, or direct irritation of these fibres in the vagus by the neuritis, would be responded to by a contraction of the stronger adductors, analogously to the results of artificial stimulation of the motor laryngeal fibres in animals. When the neuritis affects both the vagus and accessory nerves together, the conditions are favorable for the production of violent crisis. A localization of the lesions causing the other crises in tabes was based on Gaskell's description of the distribution of the sympathetic system.—Trans. N. Y. Neur. Soc., *Med. Rec.*, Dec. 21, 1889.

Electric Cataphoresis as a Therapeutic Measure.—In an article with this title published in our issue for April 27, 1889, one of our contributors, Dr. Frederick Peterson, described some of the results obtained by him in the use of cocaine, aconitine, chloroform, and helleborin, in varying solutions, with the galvanic anode. His experiments demonstrated the value of the cataphoretic method for the production of local anæsthesia and for the relief of pain in neuralgias of the superficial nervese. He suggested its employment with other drugs, such as iodine, whenever it was desirable to use them topically, ro where they were to be introduced into the system for general purposes.

The growing recognition of this method is illustrated by two recent contributions to the literature of the subject. One is a preliminary report made by Dr. Gärtner and Dr. Ehrmann to the Imperial-Royal Society of Physicians of Vienna, on November 22, 1889 (*Wiener med Blätter*, Nov. 28, 1889), upon the cataphoretic use of corrosive sublimate. An electric bath-tub with two compartments, invented by Dr. Gärtner, was employed for the purpose. From four to six grammes of corrosive sublimate were dissolved in the water of the bath and a current of 100 milliampères was passed through the person experi-

mented upon for from fifteen to twenty minutes. The urine of the patient was examined both before and after the bath. It was shown that, while previously entirely free from mercury, the urine subsequently contained this metal in as large a quantity as 1.3 milligramme, and, furthermore, that the mercury was to be detected for even so long as from four to six days after the bath. The authors expect good results on the grounds that it is an efficacious method of cutaneous mercurial medication, that the receptive surface presented to the drug is much larger than by any other means, that mercury may thus be made to influence localized morbid foci, and that exact dosage is possible, since the introduction of the medicament is in exact proportion to the current strength and duration of contact.

At a meeting of the Harveian Society in London, on November 7, 1889 (*Brit. Med. Journal*, Nov. 16, 1889), Dr. Cagney read a paper on the administration of certain drugs by electricity. He had made use of iodide of potassium in this way for the treatment of labyrinthine deafness and lead palsy. He speaks of the method as best adapted to the treatment of local disease of the skin and mucous membranes and subjacent tissues, and believes that iodine and the potassic iodide will be of particular value employed in this way. Cataphoresis had proved useful in syphilitic and other affections of the throat and especially in chronic pharyngitis.

This method, therefore, seems to present many advantages in the way of medication, and is perhaps destined to take a very important position in the therapeutic procedures of the future. It opens a way not otherwise attainable for influencing tissue metabolism and for changing morbid nutritive processes by sending the drugs into direct and immediate contact with diseased parts through a force which in itself must greatly enhance their active medicinal properties.—Editorial, *N. Y. Med. Journal*, Dec. 28, 1889.

MacDonnell on Delirium Ferox.—A Hungarian, aged thirty-five, was brought to hospital in a state of wild delirium, and became so unmanageable that it was necessary to lodge him in the padded room. The diagnosis was very doubtful, but after a few days the high temperature and the character of the evacuations enabled us to decide upon the nature of the case. Murchison mentions just such another case. He was called in to see a German gentleman, who was supposed to be mad. After four days of slight malaise, which had attracted little notice, he passed suddenly into a state of acute maniacal delirium, requiring two men to hold him down in bed. He was thought to be suffering from an attack of insanity, but with these symptoms there was pyrexia, quick pulse, temperature 102°, dry tongue, diarrhœa, but no spots.–*Montreal Med. Jour.*, Dec., 1889.

Abrams (A.) on Tetany. — The writer reports what he claims to be the first recorded case of tetany on the Pacific coast. L. M——, male, occupation, waiter; aged twenty-four; no hereditary predisposition; usual diseases of childhood. About four years ago sustained an injury to the chest of an indefinite nature, recovering completely, however, after four weeks of indisposition. Has since enjoyed good health until present sickness began; smokes to excess: does not use alcohol; denies venereal infection. Six weeks ago, while engaged at his occupation as a waiter, without warning, spasms developed simultaneously in the left arm and leg, causing him to drop a tray of dishes which he was then carrying, and to fall heavily against a table. Three days after he experienced a second attack, which was limited to the left arm. Since then paroxysms have recurred daily at intervals of an hour. The spasms are especially provoked by voluntary movements. He has had three slight attacks, confined to the right arm. At the present time the spasms are unilateral in character and confined to the left arm and leg, preponderating in frequency in the former situation. No pain is experienced during the attacks, and he describes the sensation following as one of complete exhaustion. The patient has a dilated stomach. There is decided impairment of sensation in the arm and leg, to touch, pain, localization, and temperature. Surface temperature diminished; patellar reflex increased on the affected side.

Increased galvanic irritability, the fraction of a milliampère inducing contraction, and with anodal opening tetanus at 4 m. a. He presents also the symptom of Trousseau and the increased mechanical irritability of the motor nerves. This is notably the case when we strike the facial nerve at the stylomastoid foramen, or when the finger is rapidly passed over the face from the eye

to that point. The contraction of the facial muscles on both sides at once follows this manœuvre. Pressure on the motor point of the sterno-cleido-mastoid muscle will induce torticollis, and pressure on the phrenics, singultus. Indeed, no motor point throughout the body will fail by simple pressure to cause contraction of the respective muscles or muscular groups.

There are three distinct forms of tetany, distinguished only by their origin and prognosis. The most common form is the rheumatic, or epidemic. Epidemics of tetany have occurred in Paris in the years 1856 and 1876, but in America and England none have been reported. A second variety is usually chronic, and follows certain exhausting conditions, as diarrhœa and prolonged lactation. There is a third form of this disease, which follows the removal of the thyroid gland. Billroth, up to May, 1883, had operated 78 times for the removal of enlarged thyroid glands, and in 13 cases tetany followed in the course of a few days. Experimental tetany, as induced in animals by the removal of enlarged thyroid glands, closely resembles tetany as it appears in man. Little is positively known regarding the morbid anatomy of this disease.

This case is particularly interesting, as the paroxysms are unilateral, the extensor muscles are alone involved, and the patient has a dilatation of the stomach. Kussmaul, Gerhardt, and others have reported cases of tetany with dilatation of the stomach. While the other forms of tetany have a favorable prognosis, this variety is characterized by its fatal tendency. Müller collected eight case of tetany, occurring with dilatation of the stomach, and the mortality was 66 per cent. Experiments are contemplated with this patient to determine the responsibility of alkaloids in the development of his disease.—*Occidental Med. Times*, Jan., 1890.

Neurasthenia and Dilated Stomach and its Treatment.—Carron de la Carrière has published in the *Bulletins et Memoires de la Société de Médecine Pratique* an article of considerable interest on the subject of "Neurasthenia and Dilatation of the Stomach." He describes an aggregate of symptoms often associated with dilatation of the stomach, symptoms which have been sufficiently familiar under the name of nervous dyspepsia. There is a sensation of weight and distention of the stomach after meals; this is accompanied by flushing of the face and a tendency to somnolence. These patients are apathetic, and seldom in trim for mental work; they are incapacitated for much physical exertion. Constipation is habitual. In bad cases the appetite is diminished or lost; digestion is painful and accompanied with pyrosis; and palpation and succussion give the characteristic signs of gastrectasia. Fatigue is a prominent symptom; exercise speedily tires. The eyes ache after reading a few minutes; there is a continual disposition to lie down; such patients are often more tired in the morning on rising than when they went to bed. They complain much of insomnia. Headache and backache are every-day phenomena. The extremities are cold and livid.

Dujardin-Beaumetz makes gastric neurasthenia the subject of a recent Cochin hospital lecture (*Bull gén. de thér.*, Nov. 30, 1889), and of a subsequent communication to the Society of Practical Medicine. He believes that in the great majority of cases neurasthenia is of gastric origin, and that patients affected with this malady will be found to have all the symptoms of dilatation of the stomach. He insists on the emaciated appearance of these subjects, their bilious hue, their melancholic disposition, the odd, varying, nervous symptoms, which are not, however, those of hysteria; palpation gives a splashing sound; sometimes the liver is congested, and, when the dilatation is considerable, in most cases there is a right-sided renal ectopia. These persons are always dyspetic and constipated. He mentions the various theories which have been proposed to explain the relationship between the neurasthenia and the gastrectasia, and inclines to that of Bouchard.

According to Bouchard, all the train of morbid phenomena depend on the penetration of the economy by *toxines*, which result from vicious fermentations taking place in the dilated stomach. These toxines produce a veritable systemic poisoning, and the passage of these organic alkaloids through the liver congests that organ, and gives rise consecutively to a crowding down of the right kidney, a displacement which tends to become permanent.

Beaumetz thinks that the dilatation of the stomach, which causes the nervous phenomena, will, in almost all cases, be found to be an hereditary malady; it results

directly from a toneless, paretic state of the gastric muscle; subjects of gastrectasis will be likely to transmit a similar condition to their offspring.

In the treatment of gastric neurasthenia two leading indications must be kept in view; to restore the stomach and intestine to a normal condition, and to remedy the depressed nervous state.

The first indication is the most important to fulfil. It comprehends all pharmaceutical and other means for combating the development of toxines in the digestive tube, and for restoring tone to the alimentary canal. Among the pharmaceutical agents, the antiseptics—naphthol, salicylate of bismuth, etc.—are especially useful. Dujardin-Beaumetz combines five grains of salicylate of bismuth with the same quantity of magnesia and bicarbonate of soda for one powder, to be given shortly before meals. Five grains of naphthol may be added to each powder.

Laxatives occupy an important place in the therapeutics of this malady; podophyllin, cascara, senna, sulphur, the purgative mineral waters are all recommended; the compound licorice powder is a useful preparation.

When the dilatation is considerable, lavage of the stomach by means of the siphon is indicated; putrescent matters are washed out, and the stomach is disinfected by boric acid solutions (1%) or naphthol a 1 per 1,000.

The dietetic treatment of gastrectasis comprises three indications: to reduce to the minimum the quantity of liquid ingested; to introduce food into the stomach only when that organ is freed from the remains of a former meal; to introduce the smallest quantity of ptomaines with the food. The first indication is fulfilled by a dry diet, only one half pint of liquid with each meal, and no drink between meals; soups, broths, milk, champagne, etc., strictly forbidden. To meet the second indication only two meals daily are allowed, at 10.30 A.M. and 7 P.M. For the third, the diet should be mostly vegetarian. Little or no meat, and all meats to be thoroughly cooked. Toast instead of plain bread, well-cooked vegetables, and fruit and eggs are permissible.—Extracts from editorial in *Bost. Med. and Surg. Jour.*, Dec. 19, 1889.

Bullard (W. L.) on a Case of Ophthalmoplegia Externa.—J. W., male, aged seventeen, of Ellaville, Ga., small for his age, weight eighty pounds, with feminine look and voice, began to develop an ophthalmoplegia externa seven years ago. Family history good. The author had seen but two cases previously, one at Moorsfields, London, and one at the office of Dr. Mittendorf of New York. In this case there was first ptosis in both eyes, then difficulty in looking upward, and later gradual impairment of motion in the other external muscles, until all were paralyzed. There was slight proptosis. Vision and pupillary reaction to light and accommodation normal. Lesion, of course, in the nuclei of the third and sixth nerves governing the external muscles. He refers to a case of Bery and Bramwell (*Ed. Med. Jour.*) which recovered, and to one of Kojewnikoff (*Annual Univ. Med. Sci.*, 1888) which ended fatally. In the former it was supposed to be a tubercle at the top of the pons, near the aqueduct of Sylvius; in the latter there was a capillary hemorrhage, with softening, in the nuclei of the third nerve.—*Southern Med. Record*, Jan., 1890.

Some Recent Observations on the Motor Path.—At the meeting of the Royal Society on the 12th inst, Dr. Beevor and Mr. Horsley read a joint paper giving an account of their recent experiments on the brain of the bonnet monkey (Macacus sinicus). The present paper is a continuation of those presented to the Society in 1887 and 1888, containing a minute analysis of the effects produced by stimulating the "motor region" of the cortex in the same species of monkey. In the present paper similar observations have been made on the excitable fibres of the internal capsule. The animals were etherized and the internal capsule exposed by a horizontal section through the hemisphere. By means of compasses the outline of the basal ganglia was transferred to paper ruled into millimetre squares. Each corresponding square on the cut surface was then stimulated by a minimum secondary induced current. The movements were carefully recorded. Forty-eight animals were experimented on, in eight groups, representing eight levels, reaching from the corpus striatum to the crus cerebri. In addition to mapping out accurately the position of the motor path in the capsule of these animals, Dr. Beevor and Mr. Horsley analyzed the tract itself, and found that the fibres had much the same relative position as the excitable areas in the cortex. Most

anteriorly are the fibres connected with movements (1) of the eyes; then follow in order those (2) of the head, (3) tongue, (4) mouth, (5) upper limb—the shoulder preceding the hand, (6) trunk, and (7) lower limb—the hip preceding the foot. Further, as shown by the authors in their previous experiments on the cortex, the fibres connected with extension are, in the case of the upper limb, placed in front of those connected with flexion, while in that of the lower limb they are situated posteriorly in the capsule. Another observation of great interest in connection with modern theories of representation of movements in each hemisphere is that, in stimulating the internal capsule in the manner described, bilateral movements of trunk muscles were extremely rare. When the recti abdominis were exposed and the corresponding fibres stimulated in the capsule of either side, contraction of one rectus only followed. It is desirable that careful clinical observations should be made in cases of unilateral convulsions, etc., in man, to see how far this arrangement obtains in the human species.—*Lancet*, Dec. 28, 1889.

REPORT ON DISEASES OF THE EYE AND EAR.

BY A. T. MUZZY, M.D.

Wolfe (J. R.) on Transplantation of Rabbit's Conjunctiva to the Human Eye.—Burns and scalds of the eye causing symblepharon of the lids to the globe were originally treated by operations whose object was mechanical separation of the raw surfaces until cicatricial action was complete. These were uniformally failures, as the interposed foreign substance was forced out by the advancing granulations at the bottom of the cul-de-sac. Plastic operations, where healthy bulbar conjunctiva was transferred with a pedicle to the raw surfaces of the lid conjunctiva, were and are successful when practicable. But many symblephera are so extensive that this method cannot find material for the flaps. And also on failure of this operation the cornea will lose more and more any remaining transparency. In such cases as these, it is, that the conjunctiva of the rabbit has been employed, and that with perfect success. The steps of the operation are the following, considerably modified and simplified since the first trial: (1) The adhesions are first separated by blunt-pointed scissors so that the eye can move in every direction; the conjunctival sac and cornea are cleared of nodules to secure an even surface. (2) Two rabbits are then put under chloroform, one being kept in reserve against any accident. (3) The conjunctiva lining the inner angle of the orbit of the rabbit is taken, covering the "membrana nictitans" and as far as the cornea, on account of its vascularity and looseness. If the palpebral opening be small, it is enlarged by a snip of the external angle. By means of a ligature through the free border of the lower lid, this is drawn open and kept steady and the conjunctival cul-de-sac exposed. (4) A black silk ligature is passed through the middle of the flap to be removed, a knot is tied, and the ligature cut short. This knot is for a mark of the epithelial surface, which otherwise, when the flap curls up, might be hard to be detected. (5) Then the boundaries of the rabbit conjunctiva that is to be transplanted are marked by four black sutures also secured by a knot. Putting these on the stretch the conjunctiva is separated with scissors, and spread out by means of a fine spatula on the back of the left hand. The four ligatures are then removed and the flap trimmed to proper size. It should be larger than the surface for which it is intended. (6) After the bleeding from the patient's conjunctiva has subsided, the flap, by this dry as parchment and adherent to the dorsum of the hand, is lifted by the fine spatula and secured to its position on the patient's lid by six or more ligatures. This final step is quite difficult, the assistant keeping the flap in position by the spatula while the stitches are securing it to its new position. Lint and a bandage keep the eyes closed for four days, and the ligatures may be removed the sixth or eighth day. Except in children no anæsthetie should be used, as the operation is long and tedious. In children an anæsthetic might be employed during the first step. The following case may show the transition from the old method to the new: Jeremiah J., aged twenty-two, got his left eye burned by a flash of slag from a forge-hammer nine years ago. At the Manchester Infirmary he says attempts were made to keep the eyelids apart by strings and lead and a ring round his nose. When first seen, three years after the accident,

both lids were completely fastened to the globe, the eye was "buried under the lids." After dissecting the lids from the globe the upper and outer quadrant of the cornea only was found transparent. An artificial pupil was formed, and the symblepharon remedied by transplanting rabbit conjunctiva, re-establishing the conjunctival sac fully with good vision. It is now fifteen years since this method was introduced by Dr. Wolfe. And though it gives good results, efforts are still made with mucous membrane of the mouth, and even vagina and prepuce. Otto Becker of Heidelberg, Albrecht Graefe of Halle, De Wecker of Paris, and Marc Defour of Lausanne, with H. D. Noyes of New York, and Cohn of Breslau, have successfully employed this method.—*Lancet*, London, Dec. 14, 1889.

Taylor (C. B.) on Treatment of Symblepharon. — The best method of treating extensive destruction of ocular and palpebral conjunctiva is by transplantation of skin *en masse*, without pedicle, to the surface of the eyeball itself. A patient whose lower lid was firmly attached to the globe, and no conjunctiva being useful, a piece of cuticle, one inch by two, was transplanted from the upper lid of the sound eye to the affected globe. The upper lid of the injured eye was insured from excoriations at the time of the accident. This was treated by skin graft with pedicle, giving full freedom to the eye ; the sight is perfect.—*Lancet*, Lond., Dec. 21, 1889.

Harlan (G. C.) on Hysterical Blindness in a Healthy Male Subject.—Hysterical blindness has been so well discussed that reports of further cases among women would hardly deserve attention. But this is not true where it occurs in men. And a word of warning of its possible occurrence among men may prove of interest. One of my first cases of hysterical blindness was a rather delicate-looking boy of eleven years, blind in the right eye for the previous eighteen months. After some months' unsuccessful treatment by the family physician, electricity was applied. The first application entirely restored the vision, the "cure" lasting a few weeks, the re-application of the electricity again improving the sight, so that the father invested in a battery and wound up the vision as often as it ran down. When brought to the Will's Hospital the boy denied he was conscious of the ophthalmoscopic examination, though nothing abnormal was seen. When a prism was placed before the left eye, he admitted seeing two images. These were then united by turning the prism from the vertical to the horizontal plane. He was now directed to read rapidly, and while disconcerted in this endeavor a piece of folded paper was quietly slipped before the left or good eye, when he continued to read with what was considered the useless eye. There was no apparent reason for deception. The patient's mother, however, was blind in the right eye. A second case presents several points of interest. A well-developed man twenty-two years of age, a clerk, says that ten years ago he was struck on the right eye by a stone. Considerable pain and inflammation followed, and the sight of the eye was lost. After several months' careful treatment by a competent specialist, he was discharged as incurable from optic paralysis. Ever since then the vision has been a source of much anxiety to himself and his family. Recently considerable headache and irritation had followed his desk work, and his family physician had warned him that it might be necessary to remove the affected eye to save the sound one. On consulting, he was fully prepared to sacrifice the eye if it should be found necessary to do so to save the other from damage. Vision of the left eye was normal with latent hypermetropia of 1.25. The ophthalmoscope showed no abnormality in either eye. He thought he did not detect the reflection from the mirror with the injured eye. The pupil of this eye, however, reacted normally. But prisms again gave double vision, and when + 1.25 for the right and + 4. for the left were placed before the eyes and he was directed to read, as the + 4. unconsciously prevented his using the left or good eye, he nevertheless read the finest Snellen type. This was proved to the patient by gently closing the left eye, when his surprise was only equalled by his very evident joy at the discovery. His willingness to sacrifice the eye made it very evident to me that there was no malingering in the case. The long continuance of this condition is quite interesting.—*Med. News*, Philadelphia, Jan. 11, 1890.

Bonner (A.) on Some Relations between the Diseases of the Nose and the Eye.—Attention is frequently directed to the intimate relation between the affections of the ear on the one hand

and the nose and throat on the other. But as close a connection exists between nose and antrum with the eye and orbit. If the nasal duct be closed by inflammation, epiphora is the result. And cases have been met where no stricture of the duct existed as cause for the epiphora, but where the successful treatment of thickened nasal mucous membrane removed epiphora. Phlyctenular and marginal keratitis, which shows such a tendency to recur, nearly always is accompanied by rhinitis, and the most effectual cure is proper treatment of the nares. Two cases have been treated where reading could not be continued for any length of time without severe headache. After proper attention to an existing rhinitis all discomfort ceased and ability to read returned. One case is reported of glaucoma following empyema of the maxillary sinus. — *Amer. Jour. Ophthal.*, Nov., 1889.

Mobilization of the Stapes.—A frequent result of nitra-tympanic inflammation and catarrh is fixation of the stapes, the effect of which is to diminish the sense of hearing in a marked degree. Hitherto this affection has not been considered to come within the scope of operative interference, but a French aural surgeon claims to be able to effect this by means of specially devised instruments, with the most admirable results in the restoration of the functional integrity of the auditory apparatus. The varieties of deafness in which this procedure is indicated are cases of persistent perforation of the tympanum ; the so-called "paradoxical" deafness, in which patients hear better in a noise, as when on the railway, etc. ; deafness due to gouty or rheumatic affections of the articulations of the small bones of the ear ; and in some cases of deafness due to catarrh. The more recent the ankylosis of the stapes, the easier it is to overcome, and if there be bony ankylosis the method is not applicable. The first step in the operation is to make an incision in the postero-external part of the tympanic membrane, corresponding to the descending branch of the malleus and the stapes. A fine hook is then introduced and passed between the branches of the stapes, gentle traction outwards being made. In some cases these two bones are disarticulated, and in rare instances their removal may be required, especially in grave cases of old standing. An antiseptic dressing is then applied and no grave symptoms have ever followed, although the operation has now been performed in some hundreds of cases. The permanence of the improvement is conduced to by the persistence of the tympanic perforation, and this should always be aimed at. When the bones have had their mobility restored to them, a course of "aural gymnastics" is employed, the motive force being the Politzer bag.—*Med. Press*, Jan. 1, 1890. R. W. A.

Dangerous Middle-Ear and Mastoid Inflammation Following Treatment of the Naso-Pharynx.—Dr. S. L. Thompson, of Indianapolis, reports, in *Jour. Am. Med. Assoc.*, Dec. 17, 1889, twenty cases out of many others occurring in his practice of otitis media following the use of caustics in the treatment of nasal and naso-pharyngeal inflammations, inferring from this the general frequency of its occurrence. But the histories fail to state the absence of ear inflammation before use of caustics in many, and in others state actual presence of catarrhal otitis before and during use of nasal treatment. Dr. Thompson also takes the patient's unsupported testimony in the previous history, while warning his readers against this testimony in the present condition. The point of the paper in the *second point* of the "remarks," that operations and caustics should not be applied to nose or pharynx during the acute stage of inflammations, has been many times made, and needs to be frequently repeated.

Bettman (B.) on Mastoid Periostitis.—Dividing this disease into its three stages, as that complex of symptoms called inflammation may be divided elsewhere, the *first stage*, that of accelerated blood-current and dilated capillaries, should be treated by cold. This stage of mastoid periostitis is recognized by slight redness and tenderness of the region. And the best method for applying the cold is by Leiter's coils or by wet cloths. The middle ear should be carefully cleansed with warm antiseptic solutions to encourage free discharge of purulent secretions. The *second stage*, that of retarded blood-current (stasis), with exudation of liquor sanguinis and migration of the blood-corpuscles, indicates application of heat, hot compresses, flannel wrung from hot water. To encourage absorption and avoid the third stage, the hot fomentations should be continuous, not longer than two or three hours at a

time, with long intermissions. When the *third stage*, with its cell disintegration and pus formation are inevitable, or already established, heat in fomentation should be continuously applied to hasten the process, and pus be evacuated by incision. A proper and conscientious adaptation of principles in the application of heat and cold form the main features in the successful treatment of "mastoid periostitis" complicating chronic otitis media.—*N. A. Pract.*, Dec., 1889.

SURGERY.

Treatment of Carcinoma of the Breast.—At a meeting of the Philadelphia County Medical Society, held Sept. 26, 1888, Dr. S. W. Gross (*Jour. Am. Med. Assoc.*, Oct. 20, 1888), urged the necessity of a more extended operation than is usually performed in the treatment of this disease. Dissatisfaction with the results obtained in his own practice and in that of others led him, ten years ago, to adopt a radical procedure, the object being to effect riddance of all the tissues in which the experience of hundreds of years demonstrates that a recurrence or a new outbreak of the disease takes place. He amputates, by a circular cut, the entire breast with its overlying skin and fat, dissects off the pectoral fascia, and carries an incision into the axilla, through which he is enabled to extirpate its contents. If nodules are found in the pectoral or intercostal muscles, they are removed with an unsparing hand. The edges of the wound are then approximated, the closure of the breast incision being greatly facilitated by raising the flaps from the subjacent tissue from one and a half to two inches, and the employment of button sutures. In some cases the wound cannot be entirely united, so that it has to heal by granulation. He removes the entire breast and attacks the axilla in all cases because recurrence or a new outbreak of the disease ensues in tissues which are left behind by the less radical modes of operating. The accumulated observations of surgeons show that recurrence may be expected in the skin and subcutaneous tissues, especially at or near the cicatrix, in the fascia covering the pectoral muscles, in the remnant of the breast from which the tumor alone has been excised, in outlying lobules which were overlooked during the performance of the less complete operation, and in the lymphatic glands, especially those of the axilla. Sound pathology demands that the entire mammary gland, along with its circumjacent tissues, should be amputated, first, because we have to deal with a carcinomatous degeneration commencing at one point, from which the cells migrate in various directions into the remainder of the breast and the surrounding tissues, the extent of which migration into the lymphatics and their radicles it is impossible to determine with the naked eye; secondly, because the disease is sometimes multiple, and the smaller growths are only detected on examining the breast after its removal; thirdly, because minute lobules frequently lie at some distance from the main body of the gland, particularly toward the axilla and the clavicle, which may subsequently become the seat of a new outbreak, even as late as ten years, as in a remarkable instance recorded by Banks; and, fourthly, because nodules may be found in the subcutaneous tissues at a relatively great distance from the breast, which would certainly have escaped detection in the lesser operations. He attacks the axillary glands in every case because they are almost always diseased, even though they cannot be felt prior to operation. Of his 45 cases, the glands were not palpable in 18, but in 15 of these they were present when the axillary space was opened. In 57 out of 65 similar cases, Kuester found that the glands were infected, so that their combined experience demonstrates that the glands are invaded in 86 out of every 100 cases in which there is no external evidence of their implication. Hence, if the axilla be not evacuated of its contents in every case, a subsequent operation will almost surely be demanded. Dr. Gross claims that this extensive operation is followed by better results than are any of the minor operations. Of his 45 cases, 2, or 4.44 per cent., perished from the operation, and 5 were lost sight of after recovery. Deducting the 7 that died and could not be traced, 38 cases show local recurrence in 11, or 28.95 per cent. Including the deaths, out of 40 cases, 9, or 22.5 per cent., recovered. Of these, 1 died of an intercurrent disease in 7 years and 10 months after the operation, while the remainder are still doing well, 1 for 9 years and 10 months, 1 for 9 years and 1 month, 1 for 6 years and 9 months, 1 for 4 years and 3 months, 1 for

3 years and 11 months, 2 for 3 years and 6 months, and 1 for 3 years and 5 days. Let us contrast these results with those afforded by the next best operation, namely, the removal of the breast by flaps, and the evacuation of the contents of the axilla in every case. Of 328 cases of this discription in the hands of Banks, Kuester, and Von Bergmann, 10.67 per cent. perished, there was local recurrence in 54.92 per cent., and 15.15 per cent. were cured, so that Dr. Gross' operation is safer by 6.23 per cent., is less liable to local recurrence by 25.97 per cent., and affords 7.35 per cent. more of permanent recoveries.

In an article in the Boston *Med. and Surg. Jour.* (Nov. 29, 1888), Dr. R. M. Hodges finds the results of amputation of the breast for carcinoma so discouraging that he concludes his paper with the following paragraph:

"If patients, therefore, are not cured, but are not even relieved by an excision,—if in performing an 'excision *for* cancer of the breast,' you cannot also perform 'excision *of* cancer of the breast,'—it is certainly not mere pessimism which leads me to the conclusion that any operation which proves itself so futile in a general sense should be an act reserved for circumstances within narrow limitations."

Mr. R. M. Page (*Brit. Med. Jour.*, Oct. 27, 1888) reports a case of a woman of 68, from whom both breasts were removed simultaneously for carcinoma. The woman made a good recovery, and when seen six months later was in good health.

Dr. Cazin, gave at the Third French Congress of Surgery (*Med. News*, April 21, 1888) the results of his practice from September, 1862, to 1886. He had extirpated 564 malignant tumors. The diagnosis of the tumors he had treated had not always been made beforehand, but the post-operative examinations have always settled the question. He had operated upon 102 scirrhus tumors of the breast, 60 complicated by ganglionic extension, 42 without it. In the first 60 cases he obtained 7 definite cures, 48 returns, 3 deaths, and 2 results unknown. With the 43 others he had 8 absolutely cured, 28 returned, 2 died, and 5 results unknown. He had operated on 120 encephaloids, 80 with ganglionic involvements, and 40 without. In the first 80 he had had 5 cures, 67 returns, 4 deaths, 4 results unknown. In the 40 others, 8 definite cures, 26 returns, 1 death, 5 unknown. The returns he had observed had commenced from three months to seven years after the operation. He attributes the proportion of his successes to his adhering strictly to this precept—very extensive extirpation, even when the lymphatic glands appear intact, without occupying himself with the immediate union of the wound.

Prof. Verneuil, of Paris, holds that, in the great majority of cases, cancer is a constitutional disease; the beginning may be a local trouble, which, once developed, will infect forever the system, and never is cured. There can be only occasional arrests in the development of the tumor. He had seen in a lady a cancer return in a cicatrix of the breast thirty years after the primary operation, with histological characters exactly similar to the first tumor. He always prescribes, after an operation, a permanent arsenical and alkaline treatment. He orders $\frac{1}{15}$ of a grain of arsenic a day, and a teaspoonful of magnesia every night before going to bed. He also prescribes a vegetable diet.

GERTRUDE B. KELLY, M.D.

OCCASIONAL REPORT ON SURGERY.

BY CHARLES A. POWERS, M.D.

Gibney (V. P.) on Flat-Foot.—The author, acting on a suggestion from Dr. R. Abbe, relieved a painful case of flat-foot by curing an ingrowing toe-nail which involved the great toe of the affected side. He cites, in addition, two cases of Dr. Abbe's, in which the same condition obtained, in which relief followed the cure of the nail trouble.

These cases suggest the thought that the surgeon should, in all cases of flat-foot, subject the toes to careful examination.—*Annals of Surg.*, Jan., 1890.

Brewer (G. E.) on Internal Urethrotomy.—The author, after a careful and thorough analysis of the accidents, complications, and results in one hundred and twenty cases of stricture of urethra subjected to internal urethrotomy, concludes as follows:

1. That internal urethrotomy as a means of treating stricture of the anterior urethra is a comparatively safe operation. 2. That, by the intelligent application of a few well-known measures, alarming hemor-

rhage can, in nearly all cases, be avoided. 3. That the occurrence of a more or less lasting curvature of the penis after operations is probably due to the extension of the incision beyond the necessary limit. 4. That, with the exception of the meatus, the practice of dividing anterior strictures on the floor of the urethra should be condemned as a dangerous procedure. 5. That the passage of instruments through the deep urethra should, if possible, be avoided immediately after the operation. 6. That in a majority of cases, by a thorough and complete division of all stricture bands, a radical cure and complete restoration of the canal to its normal calibre may be expected. 7. That all attempts to prevent recontraction in imperfectly divided strictures by means of dilatation are useless.—*N. Y. Med. Jour.*, Feb. 11, 1890.

White (J. W.) on a Case of Fracture of Both Clavicles.—The patient, a man, gave a history of having gotten on a railway train and having subsequently found himself lying on the ground by the side of the track. There was no evidence of direct violence, that is, there were no contusions or ecchymoses over the regions of the fractures, which makes it probable that the fracture occurred on both sides from indirect violence.

He was treated in the recumbent position, at the end of four weeks union and with use of the upper extremities.

The rarity of the accident may be understood by the following figures: In 2,358 cases of fracture of the clavicle, treated at the Hotel Dieu, only one was bilateral, and in a series of 696 cases of fracture of the clavicle, noted at the Pennsylvania Hospital, not one bilateral fracture was observed.—*Univ. Med. Mag.*, Jan., 1890.

Osler on Fatal Hemorrhage from a Large Bronchocele.—A woman, aged forty-four years, insane, the subject of goitre for many years. She was up and about helping at her work, when she became faint, breathless, and blanched, and died within a few hours. Autopsy.—The woman was well nourished, the skin of marble whiteness. An immense goitre occupied the entire space between the chin and sternum. In the lateral regions of the neck the swelling extended towards the clavicles and below the skin of the upper half of the sternum. On section, a space was opened between the bronchocele and the sternum, containing large clots, which, on dissection, were found to have come from one of the lower cysts of the goitre, which had ruptured. The blood extended into the cellular tissue of the neck and beneath the sternum into the anterior mediastinum, covering the aorta and upper part of the pericardium. The hemorrhage passed behind the pharynx and down the course of the œsophagus for two or three inches. On removal the windpipe and gullet were found almost completely embedded in the goitre, and the former seemed at its lower part somewhat compressed. The bronchocele weighed $1\frac{4}{10}$ kilograms, and was of the parenchymatous variety, with much calcareous and fibroid change; here and there were cysts. The thoracic and abdominal viscera presented no special change. The case illustrates a very unusual accident in the history of goitre. It is well known that hemorrhage frequently occurs into the cysts; Osler had not met with an instance in literature where death resulted from it.—*Johns Hopkins Hosp. Bull.*, Jan., 1890.

Maylard (A. E.) on the Antiseptic Value of Iodoform.—Notwithstanding the assertions of many experimentalists to the effect that iodoform is entirely useless as an antiseptic dressing, and that it may even convey infection to an aseptic wound, surgeons still maintain its value, and it is used in one form or another and in large quantities as a wound application at present.

This double feeling, of its apparent value in the wards and its apparent uselessness in the laboratory, led the author to carry on a long and carefully conducted series of experiments, as a result of which he agrees with Drs. Ruyter and Fenger in concluding:

1st. That ptomaines without organisms are capable of causing suppuration, and that iodoform is able so to act on the ptomaines as to prevent suppuration.

2d. That the drug must be used in large quantities, quantities largely in excess of the ptomaines or organisms.

3d. That the special value of iodoform rests on its prolonged action.—*Annals of Surgery*, Jan., 1890.

Keen (W. W.) on an Operation for Relief of Deformity from Prominent Ears.—Patient, a boy of nineteen years, with prominently outstanding ears. The author cut out a long narrow piece from

the auricular cartilage, posteriorly, as well as a generous oval flap from the skin. On one side the cartilage and skin were both sewn up; on the other sutures were placed in the skin alone. The result was equally good on both sides and materially lessened the deformity.—*Annals of Surgery*, Jan., 1890.

Pilcher (L. S.) on the Treatment of Appendicitis by Early Laparotomy.—Referring to the papers of Senn and McBurney on operative procedure before perforative evidences have declared themselves, as well as on chronic cases characterized by acute exacerbations of short duration, the author says that notwithstanding the cases of the above-named authors, the indisputable soundness of their pathology and the brilliant success of their efforts, it ought not to be forgotten, nor will it be when the final judgment of the profession is made up, that by far the greater portion of cases of acute appendicitis, those which have been hitherto classed as typhlitis or perityphlitis, recover spontaneously and permanently, without suppuration, at least without intraperitoneal suppuration. The cases classed as chronic appendicitis form a group by themselves; spontaneous and permanent recovery, however, from this condition is also not infrequent. A very grave responsibility, therefore, must attach to the surgeon in any given case in deciding upon laparotomy and excision of the appendix. It is evident that at present, at least, it could only be proper for one who was a perfect master of aseptic abdominal technique to offer such a procedure as less dangerous than the policy of delay and palliation. It is doubtless true that if in all cases in which there were present symptoms pointing to trouble with the appendix, the abdomen should be opened immediately and the appendix excised, the occurrence of immediate perforation would be anticipated in some cases, the production of general peritonitis would be prevented, and lives would be saved; on the other hand, many would be subjected to the hazards of laparotomy and excision in which there was no danger of perforation and which would have recovered spontaneously if let alone. The general principles that govern surgeons with reference to all operative work must, however, be applied here and in any given case the probabilities of every kind must be given due weight in coming to a conclusion. Surgeons may still hesitate and defer operative attack in cases of appendicitis until well defined evidences of suppuration are obtainable, and their course cannot be said to be otherwise than prudent; surgeons may boldly expose the appendix and remove it upon the first symptoms of inflammation declaring themselves, and as long as their results are as favorable as those of Senn and McBurney, their course must be considered justifiable. The next few years will doubtless accumulate an abundant experience in this new path upon which more safe conclusions for general guidance may be based than can be upon the very limited experience as yet available.—*Annals of Surgery*, Dec., 1889.

Vance (A. M.) on Antiseptic Details in Surgery.—The following notes are in no way new or original; they have been many times reiterated, yet they are again reproduced because of the terseness with which they are here stated.

Don't do any operation with suspicious [uncleanly] hands; hot water, soap, nail-brush, and penknife should be carefully used by the principal and his assistants before any operation [it is also well to immerse the hands and wrists in pure alcohol, at 90°, for one or two minutes, and then in sublimate solution, 1-1000, for at least a minute—C. A. P.].

Don't, just before or during an operation, put the fingers about your nose, eyes, or ears, or use a handkerchief or shake hands with any one.

Don't pick up, or allow an assistant to touch, any instrument, sponge, or suture that has fallen to the floor during the operation.

Don't bite off the end of a suture.

Don't put a knife or other instrument in the mouth or behind the ear.

Don't cough or sneeze over the operative field.

Don't fail to have the patient bathed, the field of the operation thoroughly cleansed, and, if necessary, shaved, before operation.

Don't allow visitors to handle the field of operation, after the patient is prepared, unless they are aseptic. [Visitors generally dip the tip of a finger in an antiseptic solution, and then introduce it in the wound. It is unnecessary to say that such practice is wholly wrong.]

Don't allow visitors who are attending patients with gangrene, erysipelas, or puerperal fever, to be present.

[To which may be added, *don't fail* to see that the receptacles in which sponges, sutures, and instruments are placed are as surgically clean as are the implements themselves—C. A. P.]—*Med. News*, Feb. 8, 1890.

Keyes (E. L.) on Nephro-Lithotomy.—The author describes in detail six cases in which he operated for actual or suspected renal calculus. In one case he removed a large, many-branched stone which weighed two ounces. He concludes as follows:

1. The posterior exploratory incision upon a kidney suspected to contain stone is devoid of any serious danger when performed with proper care, and should be resorted to more often than is at this date sanctioned by general surgical opinion.

2. The best incision is the transverse, below the twelfth rib, with as much of a liberating incision downward along the line of the edge of the quadratus as may be required to gain ample room.

3. The kidney may be freely cut into and rudely lacerated with the finger, when the stone calls for it, without producing any hemorrhage which hot irrigation will not control.

4. It is better, in the case of a large, branching calculus, to break it up and extract it in fragments, rather than to attempt to remove it entire.

5. So little danger attaches to the posterior incision that it seems wiser always to make it the first step, reserving peritoneal exploration for a later resource in cases where the posterior exploration miscarries. —*Med. Record*, Feb. 8, 1890.

Ball on Linear Proctotomy.—The author defines this operation as an incision through the anus and rectum backward to the hollow of the coccyx and sacrum, and gives the following indications for its employment: 1. For the cure of non-malignant strictures of the rectum, in which gradual dilatation by means of bougies or other instruments is either impracticable or inefficient. 2. For the removal of growths situated high up in the bowel or in the hollow of the sacrum. 3. As a palliative measure instead of colotomy in advanced malignant disease. 4. As a preliminary step to amputation of the rectum. —*Lancet*, 1889, p. 645.

Kammerer (F.) on Intussusception in a Child of Six Months Treated by Laparotomy with Recovery. — The invagination had existed for sixty hours. All regular evidences were present. The child was chloroformed and an attempt made to overcome the obstruction by water enemata under high pressure, with the child in the inverted position. This failing, abdominal section was made, and after eventration of the small intestine, the seat of the invagination, ileo-cæcal, was discovered. Disengagement was made by traction on the intussusceptum, supplemented by pressure on the intussuscipiens. The belly was sewn up, and the child made an uninterrupted recovery.—*Med. Record*, Feb. 1, 1890.

Phelps (C.) on the Radical Cure of Varicose Veins by Multiple Ligation. —The author ligates the veins subcutaneously, using a Keyes-Reverdin needle, and applies a large number of ligatures to a single vein. He has operated upward of a hundred times, and unhesitatingly commends the measure as the best method for obtaining permanent occlusion of veins. He would restrict the operation to the following cases:

1. Where this condition constitutes disability in physical examination—as for admission to the army or navy, or for appointment in a municipal department.

2. Where the size of the veins, the formation of venous tumor, or the attenuation of the coats or tegumentary coverings threaten hemorrhage.

3. Where chronic ulceration or eczema exists.

4. Where circulation has been so far impaired as to occasion swelling of the feet or loss of power in the limb.—*N. Y. Med. Jour.*, Dec. 28, 1889.

Cabot (A. T.) on Bony Anchylosis of Temporo-Maxillary Joint Relieved by Osteotomy of the Neck of the Inferior Maxilla.—He reports three cases in which the operation had been done with permanently good result. In the first case, only the neck and the head of the condyle were removed, but in the two others, owing to extensive new-formation of bone, it was necessary to cut away the coronoid process as well. In all three cases the functional result was excellent.

The writer gives preference to the external incision at first described by Bottini, rather than to the internal operation of Dr. Mears, on account of the greater exactness with which the operator could, by the outside incision, remove just so much of the

bone as was necessary, and because he felt that, in the last two cases reported by him, the forcible twisting off of the upper end of the ramus would have been very difficult, and its thorough removal wellnigh impossible.

He calls attention to two signs by which, in a jaw anchylosed on one side, it could be determined which condyle was fixed. First, the slight springing that such jaws are capable of by forced efforts at mastication is a little more noticeable on the side on which the condyle is free; and secondly, owing to the loss of bone which accompanies the anchylosis, the lower jaw is displaced toward the affected side, which displacement can be perceived by comparing the intervals between the upper and lower central incisors.—*Boston Med. and Surg. Jour.*, Jan. 2. 1890.

Bennett (W. H.) on the Radical Cure of Varicocele.—The author believes the "open" method to compare favorably with the "subcutaneous" plan of treatment. It is simple in practice, certain in result, and in the hands of any surgeon who is reasonably attentive to detail, and who observes ordinary antiseptic precautions, there is, he thinks, no risk of any kind directly connected with the operation; at all events, if there be risk it is avoidable. The essential part of the open method is the formal exposure by dissection of the portion of the varicocele about to be subjected to the operation for the radical cure. The obliteration of the veins thus exposed is then ordinarily accomplished by one of the following procedures: (1) The encircling of the veins by a single ligature; (2) the complete division of the veins between two ligatures; (3) the excision of a portion of the varicocele previously included between two ligatures. He shortens the cord by bringing together the cut ends of the veins, and believes that if the testicle is raised by shortening the cord, the scrotum will, be it ever so long and flaccid, spontaneously contract and accurately adapt itself to the testicle in its new position.—*Lancet*, Feb. 9, 1889.

Power (D'Arcy) on a Complete Case of Ossifying Sarcoma.—A girl, aged thirteen, applied for relief on account of a swollen knee, which was apparently due to tubercular synovitis. As the knee rapidly increased in size, and a gland appeared in the groin, the patient was admitted into St. Bartholomew's Hospital. A few days after her admission it was deemed advisable to amputate her thigh in the middle third. Subsequent examination of the limb showed a large ossifying sarcoma surrounding the condyles, and extending along the shaft of the bone for nearly six inches. A month after the amputation an enlarged gland was removed from the groin. It was found to be so firmly attached to the femoral vein that an inch of that vessel was removed with it. The gland measured two inches across, and was of such bony hardness that it had to be divided with a saw. Two and a half months later the patient died, and Mr. Power was able to show a series of specimens illustrating the secondary growths in the lungs, ribs, and clavicles, as well as a very large deposit in the ilium. Microscopical examination showed that the growths were all of the same nature, consisting of a round-celled sarcoma embedded in a vascular matrix of true bone.—*Brit. Med. Jour.*, Feb. 23. 1889.

REPORT ON SURGERY OF THE RECTUM AND INTESTINES.

By

C. B. KELSEY, M.D., AND BLAIR GIBBS, M.D.

On Fistula in Ano and Consumption.—Schuchardt, in *Sammlung clinischer Vorträge* (Volkmann's) calls attention to the well-known relation between consumption and fistula in ano and to the proof that the majority of fistulæ are due to local tuberculosis. To Volkman belongs the credit of having first shown the tubercular nature of these fistulæ, and in the clinic at Halle the presence of tubercle-bacilli is shown by microscopical examination or by inoculation into the anterior eye-chamber of rabbits. Very interesting and demonstrative of the specific character of the disease is the well-known case of Volkman in which the secretion from the fistula infected the skin of the anus, giving rise to a lupus foliaceous, and it is at the same time a proof that lupus is a skin tuberculosis. In this case the inguinal glands became tubercular.

The secondary lupus occasioned the tubercular bubo in the same way that the inguinal glands are affected in cancer of the rectum, only by the incroachment of the carcinoma on the skin.

As to the pathogenesis of fistulæ of this character, very small lesions of the mucous membrane afford the point of entrance to the tubercular virus, and it is characteristic that these small lesions of the gut must be present so that the germs imported in food or in the swallowed saliva may find their way into the loose periproctal tissue. Large ulcerations, also occur in the rectum, but rarely give rise to tubercular periproctitis. Only in isolated cases in which no opening in the mucous membrane can be found, is a primary connective-tissue tuberculosis to be thought of. The rectum, like the cæcum and vermiform appendix, is very liable to acute inflammation, and to chronic ulceration from stagnation, etc., of the bowel-contents, and, to complete the analogy, perityphlitic abscesses are seen having the character of tubercular abscesses.

The propriety of the removal of tubercular fistulæ has long been proved. The old idea that the fistula represented a beneficial, natural, derivative action, which hindered the development of the phthisis, has proved false when investigation showed both diseases to be due to the same cause. A local tuberculosis should be removed wherever found, as thoroughly as possible, by incision and scraping.

Cancer of the Rectum.

Many interesting points were brought out by Mr. Jessop at the annual meeting of the British Medical Association.

Speaking of the frequency in which complete obstruction occurs, he finds that in one hundred and two cases where the cause of the disease was not interfered with in his own practice, less than one in three died from this complication. He calls attention to the fact that when the disease is low down in the rectum, complete obstruction rarely occurs, and that the reverse holds good when the growth is high up. The reason for this is found in the anatomy of the parts; for, whereas the rectum as it approaches the outlet becomes more closely applied in the sacrum and pelvic wall, in its superior portion it is comparatively free, and thus the contractile action of the colon above is exerted with effect in forcing the contents through a contracted ring when that ring is fixed and immovable; whereas, when the narrow portion is free, movable, and not attached, as it is when situated in the upper part of the rectum, the efforts of the bowel above succeed only in invaginating or otherwise displacing the growth, and fail altogether in effecting any onward movement of the contents.—*Brit. Med. Journal*, vol. ii., 1889, p. 405.

Levy on a New Method of Resecting the Rectum.—This operation is applicable to the same class of cases in which the Kraske method has been recommended. The first incision is made horizontally across the sacrum, about one half inch above the cornua coccygea. This should be from four to four and a half inches long, and down to the bone. From the two ends of this incision two cuts are made downward, about four inches, through the entire thickness of the gluteus maximus. Into one of these vertical incisions a hook is inserted, and the soft tissue pulled well outward. The lateral portion of the sacro-sciatic ligament is thus laid bare, and both the posterior and anterior sacro-sciatic ligaments are divided close to the edge of the bone, in the line of the posterior incision. The same thing is then done on the opposite side, and by means of an elevator the connective tissue on the anterior wall of the sacrum is freed. The skin-flap, with the bone attached, is then turned down by a strong hook, and a large part of the rectum brought into view. Through this opening, after the connective tissue has been separated, one is able to reach downward to within three quarters of an inch of the sphincter and upwards to the sigmoid flexure. If necessary, still more of the sacrum can be removed. After resecting the bowel, the ends are brought together by a double row of sutures, the flap is brought back to the original position, the excised portion of the sacrum held in place by bone-suturing, and the horizontal incision closed. The vertical incision may be either packed with iodoform gauze or else closed, except at the lower extremities, which should be left open for drainage.

This operation is based on the fact that, as the floor of the pelvis is left intact, neither incontinence nor prolapse is likely to occur.—*Centralblatt für Chirurgie*, March 30th, 1889.

Brokaw (A. V. L.) on Intestinal Anastomotic Operations with Segmented Rubber Rings, with Practical Suggestions, etc.—For many months the author has been experimenting with segmented rubber rings in all the anasto-

motic operations, and such operations as gastrostomy, cholecystotomy duodeno-cholecystotomy, jejuno-cholecystotomy, and circular enterorrhaphy. The rings used by him are rapidly made, during an operation if necessary. All that is required is some rubber tubing or a soft ordinary rubber catheter and some cat-gut. He prefers tubing one sixteenth to one eighth of an inch in diameter. A section of this, of sufficient length to make a ring of the desired aperture, is cut into four or eight segments. Passing heavy strands of cat-gut through the lumen of these pieces, the ends are tied tightly enough to bring the ends of all segments together, forming an oval ring. To the cat-gut strands are tied from four to six silk apposition threads twelve to fourteen inches long, and the attachment of needles to these threads renders the ring ready for use. Another method is to pass a heavy double strand of cat-gut continuously through the segments several times; approximate the ends of the segments, and push the ends of the cat-gut into the tubing. The ring will have a better surgical finish, and after the apposition threads are tied between the segments the ring will maintain its perfect form until the cat-gut is absorbed. The rings were passed as early as the fifth day in one of his experiments. In forming an anastomosis, after ordinary No. 6 darning needles are attached to the apposition thread, compress the ring and pass it through the opening made in the lumen of the bowel; then pass the threads through the intestinal wall from within outward. Ascertaining that the ring rests well in place, proceed to the second in the same manner; appose, and after scarification of the marginal serous surfaces, as suggested by Senn, tie the apposition threads. When possible, it is well to utilize omental grafts which add to the security. With two such rings circular enterorrhaphy may be performed, the rings corresponding in size to the lumen of the bowel, care being taken that they are not so large as to press too much upon the delicate mucosa or to overstretch the bowel, as a local gangrene might then follow. Introducing a ring at each end of the gut at the point of section, the threads are passed through the wall less than one third of an inch from the divided margins. The distal end of the gut is invaginated and the proximal gut pushed into the distal, bringing the serous surfaces in contact. The threads are then tied, and a few Lembert sutures added, the entire operation requiring less than ten minutes. In one half of his experiments with this operation the result was excellent. Of the fourteen dogs operated on by this method, in seven the results were all that could be desired; marked stenosis was found in several cases, and in all a ridge at the seat of the operation.

In a recent paper the essayist mentioned a new procedure of closing large wounds of the intestine, especially gunshot, whereby ordinary suturing stenosis would result. This method applies to wounds of the surface of the intestine; those of the mesenteric portion usually require resection. By this simple method wounds the size of a half dollar may be closed in less than five minutes. The wound being trimmed and enlarged with scissors, a ring two and a half inches in diameter, is made of eight segments of tubing, with six apposition threads, two on each side, so arranged that when the apposition threads are tied the ring is held bent evenly on itself. Such a ring is introduced into the bowel, the end apposition threads passed, then the lateral, using a single cat-gut suture in drawing the wound margins together at the point of flexure in order to prevent eversion. A few Lembert sutures complete the operation. If two wounds are close together in the same loop, a lateral anastomosis might be formed if possible. With more than two wounds close together, excision and lateral anastomosis will require less time than circular enterorrhaphy or the sewing up of several wounds. Other conditions where the single ring may be used are perforating ulcers, fistulæ, etc. The great advantage of the segmented rubber rings over other devices is the simplicity of their construction and the rapidity with which any number may be made. The large aperture of segmented rings makes it possible to perform ileo-colostomy by the following method, which the author believes is original: The ileum being divided a short distance from the cæcum, the divided end of the distal bowel is invaginated into itself and secured by a continuous suture through the serous and muscular coats. Above the proximal end, a clamp is placed, and a ring adjusted to the lumen; a slit is then made in the convex surface of the descending colon and a ring introduced. The bleeding checked, the proximal end of the divided ileum is

inserted into this slit, the threads tied, and Lembert sutures added.—*Atlanta Medical and Surgical Journal*, Dec., 1889.

REPORT ON DERMATOLOGY.

BY CONDICT W. CUTLER, M.D.

McLaughlin (T. N.) on Arsenic Sulphide in Skin Diseases. — Dr. McLaughlin has found arsenic sulphide a more satisfactory remedy in skin diseases than any other preparations of arsenic. One case of psoriaris, having been treated by arsenic internally for twenty years without result, yielded readily to treatment with arsenic sulphide, a marked improvement being noticed within a month from the beginning of the administration. Another case of psoriaris, which had been treated for six years without result, was entirely cured with this preparation of arsenic within a few weeks.

He has given it in cases of *acne* and *furuncles*, where he has been in the habit of giving *calcium sulphide*, and the results have been more satisfactory from the arsenic than from the latter.

He has employed this drug in a large number of cases of *eczema*, and has *not* observed the slightest irritation or *contra-indication* to its use. These cases have all been of a *chronic* character, and he has been careful to give it a severe, thorough test. *The dose can also be conveniently increased or diminished as the case requires, and there is entire absence of any irritation of the stomach or intestines.*—*Medical Standard*, Jan., 1890.

Brocq (L.) on Visceral Disorders Following the Rapid Cure of Chronic Eczema.—The notion that it will not do to cure a chronic skin disease for fear of visceral complications was pretty firmly rooted in medical minds some years ago, but of late years this fear has been looked upon as groundless. Modern researches in the school of Vienna are tending toward the truth of the opinion held by these older practitioners, and for this reason students well posted in the tenets of dermatology hesitate to attempt the suppression of chronic eczematous rashes. *It is doubtless true that in the far greater number of cases there is no warrant for the old doctrine, and the physician may treat his cases fearless of visceral accidents. Nevertheless, it is a common thing, in gouty and rheumatic patients suffering from chronic eczema, to see articular swellings and congestive attacks affecting the lungs, the digestive tube, the liver, the kidneys, after the disappearance of an eczema.*—*The Medical Age*, Jan. 10, 1890.

Kopp on Ichthyol in Cutaneous Diseases.—Kopp has made a series of therapeutical experiments regarding the value of ichthyol, internally and externally, in the treatment of certain cutaneous diseases. The results may be briefly summarized: In acne rosacea the internal administration, about fifteen grains daily, appeared the more valuable, although improvement, usually temporary, could often be effected by external application of a ten per cent. solution or ointment. In simple acne, its external use was of decided advantage, and in some cases its internal administration was of service. In erysipelas the application of a thirty to fifty per cent. ointment was of benefit. In burns and frost-bites of the first and second degree, the drug was efficacious, used variously in solution or ointment of ten to twenty per cent. strength. In eczema its local application was uncertain, and, upon the whole, without striking results. In several cases of the neurotic type it acted favorably. Given internally, it was useful in those cases in which digestive disturbance was a factor. In prurigo it proved far inferior to other known applications. Pruritus was treated both externally and internally with ichthyol, but the results were not encouraging. At times its application proved palliative. The benefit from its local use in seborrhœa sicca was not sufficiently striking to warrant its employment in preference to the more common and less unpleasant methods. Internally, however, in several instances it appeared to possess some influence in preventing relapses.—*American Journal of Medical Sciences*, January, 1890.

Rohè (G. H.) on Lassar's Paste.—In acute or subacute eczema, great satisfaction will be obtained from the use of Lassar's paste. It is as follows:

℞. Acidi salicylici pulv., gr. ix.
Pulv. amyli,
Zinci oxidi, āā ʒ ii.
Adipis dehydrat., ʒ ss.
M. Ft. unguent.

This may be applied to the most acutely inflamed surface without fear of producing

irritation. In its original form vaseline was used as the base, but as it so frequently acts as an irritant, it should be rarely used in ointments. Another objection to the use of petroleum bases is that they are not saponifiable and hence do not yield readily to the detergent influence of soap and water.

Lassar's paste is not only valuable in eczema, but also in acute dermatitis the result of burns, frost-bite, chemicals, etc.—*St. Louis Med. Mirror*, January, 1890.

Fabry on the Treatment of Psoriasis with Chlorohydrate of Hydroxylamin.—Fabry gives a report of twenty-four cases of psoriasis, treated in Deutrepont's clinic at Bonn with hydroxylamin, according to either of the following formulæ:

℞. Hydroxylamin muriat. . 0.2—0.5
Spirit. vini 100
Calcar. carbon. . q. s. ad ventr.—m.
Sig. Apply with brush.

℞. Hydroxylamin muriat. . . . 1.0
Aquæ fort. 1000.0
Calcar. carbon . q. s. ad ventr.—m.
Sig. Apply with wet cloth.

Before applying, the scales must be removed by alkaline baths. As the drug has toxic properties, it is better to begin with a weak solution, say 1 to 1,000, and gradually increase in strength.

The advantages claimed for the new drug are: cheapness; it does not stain the clothing; it does not cause dermatitis, while it is quite as active in removing the lesions of psoriasis as chrysarobin or pyrogallic acid.—*Cleveland Med. Gaz.*, Dec., 1889.

Baumler on Erythema Nodosum and Allied Eruptions.—Baumler, who believes erythema nodosum and erythema multiforme to be forms of the same disease, expresses the opinion that it is to be regarded as an infectious disease, a view which has of late years gained ground in Germany and France.

As reasons, the author gives: the often severe general character of the affection; the high, long-continued fever of a remittent type; the inflammation of the skin and mucous membrane, sometimes leading to the formation of pustules; the affection of the joints, sheaths of the tendons, serous membranes, and endocarditis. With such manifestations the erythematous or nodose varieties of the disease may bear the closest resemblance to other well-known infectious diseases, such as varicella, variola, and syphilis, with which they may be (and have been) confounded, as Hutchinson and Lewis have in former years shown. Reference is made to the observations of Uffelman and Oehme, in 1876, who attempted to show some relation between erythema nodosum and (the now recognized infectious disease) tuberculosis. — *American Journal Medical Sciences*, Jan., 1890.

Krupp (H. E.) on the Treatment of Eczema.—Dr. Krupp divides the local treatment of eczema into three classes, namely: the protective for the acute stages; the mild astringent for the subacute stages; and the stimulating for the chronic stages of the disease.

Acute cases of erythematous or vesicular eczema require the protective treatment. The part should be kept dry and clean, and when necessary to wash for purposes of cleanliness the water should be rendered as bland as possible by the use of bran or a little borax, and soap should be used as little as possible. Some of the best protectives to use in this stage are lycopodium, starch, ung. aquæ rosæ, and ung. zinc. ox. When these means have failed, or the disease has become subacute, mild astringents added to these protectives are called for, and among them we may mention diachylon ointment, subnitrate of bismuth, and Goulard's lotion and water. To allay the itching there is nothing better than camphor, either the powder or the spirits.

In chronic eczema the more stimulating applications become necessary, and among the best of these may be mentioned the white precipitate ointment, tinc. saponis viridis, and solutions of liquor potassæ. Fats cannot be borne by some skins, and vaseline will frequently produce eczema. When these bases for ointments cannot be borne, lanoline or glycerite of starch may be used with good result.

Before active remedial treatment can be undertaken, all scabs and crusts must be removed, by thoroughly soaking the parts with some bland oil, as olive or cod-liver oil, and then washing with a strong solution of borax or bicarbonate of soda. Although the general plan of treatment of eczema, wherever situated, is the same, yet it has to be modified more or less, according to situation, whether on head, body, extremities, or is universal.—*Maryland Med. Journal*, Jan. 8, 1889.

Saalfeld on Treatment of Lupus Vulgaris with Balsam of Peru.—Saalfeld, in view of the favorable results ob-

tained by Landerer in the treatment of various tubercular affections with the balsam of Peru, was led to employ it in lupus vulgaris.

The crusts must first be removed with soap and water, and the remedy applied twice a day with a brush. The results up to a certain point were very satisfactory, but not curative. The author believes, however, that it is the best local remedy to apply outside of the more radical methods of treatment, such as scraping and cautery, and thinks it to be of advantage to use before radical measures are adopted, as it seems to prepare the tissues so that better results follow.—*American Journal Medical Sciences*, Jan., 1890.

White (J. C.) on an Unusual Form of Dermatitis Venenata.—Dr. White reports an unusual case of dermatitis resulting from the exposure to the skin of chlorine gas. The patient was a school-girl who, forty-eight hours before the attack, had been engaged in making chlorine gas, and, the generator having broken, the gas escaped in such quantities as to almost suffocate her. On examination, forty-eight hours after the inflammation had begun, the skin, from the middle line of the forehead downwards, was uniformally red, swollen, and presented considerable areas of papules, vesicles, and oozing points. The eyelids were half-closed. The neck was in an erythematous state as low as the level of the dress, where it abruptly ceased, forming thus a sharply defined margin to the inflammation. The subjective symptoms in the part were great itching and burning. The whole aspect was that of an intense, artificial dermatitis of an eczematous type. A local treatment, adapted to a case of acute eczema, was ordered, and the girl made a rapid recovery.—*Boston Med. and Surg. Jour.*, Dec. 12, 1889.

Tunis (J. P.) on a Case of Gangrene of the Cheek Following Typhoid Fever.—On October 15th a boy, eight years of age, was attacked with typhoid fever, and two weeks later a small livid, red lump appeared on the right cheek opposite the first molar tooth. Pressed between the thumb and forefinger, it was firm and hard, and gave the patient much pain. The lesion enlarged rapidly, and under the continuous application of hot flax-seed poultices, a gangrenous slough formed, which was very offensive to the smell. One week after the appearance of the lesion, the slough partially separated from the healthy tissue by a ring of granulations, which was surrounded by an area of intense congestion. The slough included all the tissues from the epidermis to the mucous membrane, and remained in diameter 2¼ by 1½ inches. Bathed in a constant flow of saliva, it emitted a pungent, fetid odor. The child had no fever and had a good appetite, but was extremely emaciated, and the circulation was very poor, the hands and feet being cold and clammy. The disease progressed until the inferior maxilla was exposed in its entire width for 2½ inches. The periosteum ulcerated off, and the bone below was discolored, leaving five teeth loose in their alveoli, which subsequently fell out. After reaching this extent, the disease began to improve under the following treatment, and is now progressing nicely toward recovery.

The opening in the cheek has been washed daily with a boracic acid solution (gr. xv. to f ʒ j), then protected by a layer of lint covered with boracic ointment (gr. xx. cosmoline ʒ j), then half a dozen layers of bichloride gauze covered with a thick layer of absorbent cotton, and held in place by a bandage. This dressing was renewed daily.

Dr. Ashhurst, in speaking of this case, said: "Such a case of gangrene, occurring in a child after typhoid fever, is extremely rare. Cancrum oris, or gangrenous stomatitis, (a better name), though presenting many features analogous to those observed in this case, is especially apt to occur after measles, and, unless promptly and effectively treated, usually terminates fatally while the gangrenous process is still spreading.—*University Med. Mag.*, Jan., 1890.

Wertheimer on Universal Cutaneous Pruritus.—Wertheimer has used the salicylate of sodium in a number of cases of universal pruritus, and has had exceeding good results, both in severe and light cases of this disease. He uses the drug in a three-per-cent. solution, and directs his patients to take an ounce of this three or four times a day.—*Amer. Jour. Med. Sci.*, Jan., 1890.

Jamison on Sodium Ethylate in Moles.—Dr. Jamison has found sodium ethylate extremely useful in removing hairy moles, but it must be applied with care, and he gives the following directions for its use:

Cut the hair as close to the mole as can be done with a very fine pair of scissors, and then paint it over with sodium ethylate by means of a fine glass rod. When the mole has a varnished look from the application, he gently rubs the ethylate in with the glass rod to make it penetrate more deeply into the hair follicles, being very careful not to let any of it run off the mole on to the skin of the face. After the operation the mole will have a black look, and a hard crust will form over it, which will be nearly three weeks in becoming detached. When it comes off the hair will be destroyed, and the surface of the mole will have a somewhat cicatricial appearance, of a much lighter color than before.

He has employed the same method in treating vascular areas, seen on the sides of the nose in children, formed by a group of dilated vessels, and with excellent result, as no mark at all is left.—*Med. Standard*, Nov., 1889.

MISCELLANY.

Hadden (W. B.) on a Subjective Sensation of the Mouth in Women.—All the patients were women of adult or advanced life. The onset is stated to have occurred at the ages of thirty-nine, fifty-two, sixty-three, and seventy-four. In every case the sensation was described as being an intolerable burning of the tongue, extending sometimes to the lips and the roof of the mouth. In the two cases last recorded, the sensation was especially severe at night, and also at any time of the day when the patient lay down. One of the patients had a small epulis of the upper jaw, and another enlarged papillæ on the tongue. These local conditions in all probability had no essential share in causation, although it is possible they had some influence in intensifying, and perhaps in predisposing to, the subjective sensation. Disregarding one patient, the woman with an epulis, whom I saw only once, the other patients were nervous, excitable individuals, who flushed readily. In the case last described in this paper, the influence of shock in intensifying the local feeling is well exemplified. This affection no doubt is "functional," and forms a well-defined group in that large class of subjective sensations in women. The distress and misery which this condition entails, and the serious way in which sleep is interfered with, are well illustrated in the following cases.

The first patient who came under my notice was a lady aged seventy-four. She was suffering from aortic regurgitation, with irregularity of the heart and dyspnœa. From the history it would appear that the cardiac trouble had been in existence some years. She was quite aware that she was the subject of serious heart disease, but she looked upon this as trivial compared with the misery entailed by the local condition in the mouth. For six months she had had an almost constant burning and scalding sensation about the tip of the tongue and lips, which made her life wellnigh intolerable, and which seriously interfered with sleep. There was nothing objective in the mouth. She suffered somewhat from flatulence and constipation, but this did not appear to be related in any way to the local state. She was very nervous, easily excited and frequently flushed with little or no obvious cause. At first I was inclined to think that the sensation in the mouth might be due to some vascular change caused by the valvular incompetency; but in the light of the cases which I saw subsequently I feel considerable hesitation in invoking this explanation. The local sensation was slightly relieved by the use of cocaine tablets containing one sixth of a grain, and later one third. For a week I tried tincture of belladonna in doses of ten minims three times daily, though without effect. The patient died a few months after I first saw her, the local condition persisting with little change until the end.

In the early part of last year two other cases of this kind came under my observation. The first, to which I have already alluded, was that of a married woman of thirty-nine, who had a small epulis. The local feeling in the mouth was such as has been described. Unfortunately I have only a very brief note of the case, and I was unable to see her again after the first visit. The other patient was a married woman of seventy-five, whom I still see from time to time. There was no history of nervous disease or of "nervousness" in her relatives. She had always been a healthy woman, and had suffered from none of the symptoms incidental to women at the cessation of the catamenia, which occurred in her case at forty-nine. She had seen better days, and clearly felt the change for the

worse in her social life. Her face reddened easily, and she was emotional and nervous. Her account was that twelve years ago she began to suffer from a burning sensation of the tongue, referred to the middle of the dorsum. Since that time the feeling has never left her even for an hour, has slowly grown worse, and has extended during the last five years to the gums and roof of the mouth. Six years ago she had excellent teeth; but when the gums began to burn, the teeth became blackened and decayed. About this time she was seen at St. Thomas' Hospital by my colleague Mr. Pitts, who tells me that he cauterized some enlarged papillæ on the dorsum of the tongue near the tip. I examined the mouth, and found the tongue was moist, clean, somewhat fissured, and with prominent papillæ. When touched with the finger she said that the sensation was "like burning." There were some minute papilla-like out-growths on the gums, and the same sensation of burning was felt when the gums were touched. I took the temperature of the mouth on several occasions, but it was always normal. There were many old fangs, and the few teeth that were left were carious at the roots. She could detect sugar and salt, but mutton, beef, and other kinds of meat tasted bitter. A few days previous to her visit she had some cod, but could not tell what it was. She said it tasted like boiled bread. She complained also of a constant bitter taste in the mouth. The quantity of saliva was thought to have increased of late. The sensation of heat in the mouth was always worse at night, and so severe was it that the patient declared that she never slept. About this she was very emphatic, and when pressed hard would only admit that she occasionally "fell into a stupor." Constantly during the night she had to sip milk-and-water to relieve the discomfort. Sometimes she tried to sleep in the afternoon, but without success; the burning became intolerable as soon as she lay down. It was very clear from her statements that the local condition had made her life a burden, and had interfered to a serious extent with sleep. For the preceding six or eight months she had been unable to take solids, because of the burning pain which was excited. Accordingly during this time she had been obliged to live upon fluids. For many years she had suffered from nettle-rash, with great itching, chiefly occurring at night. For six months I tried many remedies, likely and unlikely. Among the drugs employed were jaborandi, bromide and iodide of potassium, belladonna, chlorate of potash, antipyrin, and the local application of glycerine of borax and boroglycerine. No benefit was derived from any form of treatment.

The last patient was a florid, excitable, married woman of fifty-three. There was no history of neurosis in the family. The catamenia ceased at the age of forty-five, and shortly afterwards she began to suffer from flushing of the face, which still persists. About a year ago the tip of the tongue began to tingle. About a couple of months later she received a shock from seeing a brother, just come from abroad, who was suffering from a cancerous affection of the face. The slight tingling of which she had previously complained was at once replaced by a burning sensation of the tongue, which soon extended to the entire mouth. At first the burning was almost confined to night, and was especially noticed when the patient retired to bed. Now the feeling of heat is constant, but becomes worse at times. The sensation is somewhat relieved by eating food and by sipping water and cooling drinks. She complained that she slept badly, and, like the patient last described, she said that her sleep was more like falling into a stupor. She could detect sugar and salt, but meat tasted very insipid. There had been no noticeable alteration in the quantity of saliva. The mouth presented a normal appearance, and sensation was natural. The feeling of heat was not induced by touching any part of the fauces or tongue. All the teeth had been removed with the view of alleviating the local distress. All remedies failed to relieve.—*Lancet*, Jan 25, 1890.

Atkinson (I. E.) on the Oxytocic Action of Quinine.—The author concludes that:

1. The cinchona preparations have not a fixed and definite influence in causing contractions of the uterus.

2. An oxytocic action is occasionally produced by these remedies. This action depends upon idiosyncrasy; and, as in the other idiosyncratic reactions to cinchona, it is impossible to foretell, in any given subject, its manifestation.

3, There is some evidence that this ac-

tion is only exerted under large doses or in debilitated subjects.

4. Cinchona and its derivatives should be employed during pregnancy with great circumspection, and should be at once withheld upon the supervention of symptoms indicating a uterine-motor influence. —*Amer. Four Med. Sci.*, Feb., 1890.

Bennington (R. C.) on Varicose Veins in Vagina, an Unusual Cause of Accidental Hemorrhage.—In April, 1880, a woman called upon me to engage me to attend her in her confinement, which she expected at the end of August or beginning of September. It was her second confinement. I elicited from her that during her previous pregnancy she had had occasional attacks of flooding. A week or two after this interview she called to tell me that she had had a sudden attack of hemorrhage from the vagina the day before not accompanied by pain, that it left off as suddenly as it commenced, and that to-day she was "quite well." I made a vaginal examination, and satisfied myself that it was not a case of placenta prævia this time, but I could find no condition to account for the hemorrhage.

On May 9th I was passing her house, and thought I would call in and see her. She expressed herself as glad to see me, as she thought she was about to have another attack. I questioned her and found she had a sensation of weight and fulness "in the womb." I immediately made a vaginal examination, and found the vagina full of structures that felt exactly like soft movable sausages. I at once separated the labia and inspected the parts. The labia were much enlarged, and varicose veins were everywhere apparent, and inside the vagina were veins black and tense, as large as a forefinger. I instructed her to keep to the horizontal position with the pelvis raised, and to apply cold water to the parts. She, however, got up to see me to the door, and while standing a great flow of blood took place, lasting about a minute. I examined her again within a few minutes, and found the previous condition had absolutely disappeared, and nothing remained so far as I could tell without a speculum to indicate the source of the hemorrhage.

I insisted upon her taking rest in the horizontal position for some days, and told her to rest as much as possible during the remainder of her pregnancy, and to send for me at once if she felt another attack was imminent. I saw her two or three times till May 15th, when nothing more occurring I left off attendance.

On May 27th she had another attack of hemorrhage, exactly the same as before. I saw her after it occurred, but I have no note of any examination at that time. On June 25th I was hurriedly called to attend her, as labor had commenced; I found the membranes ruptured, the liquor amnii drained away, and an arm in the vagina. I administered chloroform; pushed up the arm; turned and delivered; the child was dead. She made a good recovery.

On October 10, 1881, I attended her again in another confinement: normal presentation, but lingering labor, necessitating forceps. During this pregnancy, although there was considerable varicosity of the parts, there was no hemorrhage.

There are several points of interest in this case to such as are engaged in obstetric work. The bursting of varicose veins is usually considered of very serious import; here we have a patient who lost blood profusely, and who seemed no worse for it, and it has raised in my mind the question as to whether any of the cases of irregular losses of blood per vaginam, so-called menstruation, during pregnancy, or some cases of accidental hemorrhage, may not be accounted for in a similar manner. —*Medical Press*, Jan. 15, 1890.

Duncan (W.). Should Pregnancy be Terminated Prematurely in Cases of Phthisis?—A woman, aged twenty-seven, had borne two children; both labors had been difficult, and symptoms of phthisis, to which she was already subject, increased during both pregnancies. Her period ceased in August, 1889. Two physicians of authority had seen the patient, and considered that pregnancy, especially if it continued to term, would shorten her life. There was a cavity near the left apex; the lower part of the left lung and the upper part of the right showed signs of crepitation. The patient was placed in the lithotomy position, the cervical canal rapidly dilated by Hegar's dilators up to No. 22, the fingers inserted, and the fœtus and membranes removed. The uterine mucous membrane was curetted, the cavity irrigated with a hot mercurial douche, and a twenty-grain iodoform bougie was introduced into the uterus, and retained there by a glycerine plug passed up to the

os uteri. The operation, performed on September 14th, lasted twenty-five minutes. The patient made a good recovery. Dr. William Duncan believed that during pregnancy phthisis was not retarded, as was formerly believed, but hastened. This was especially the case in women between twenty and thirty years of age. When phthisis was progressive, in early pregnancy, there could, in Dr. William Duncan's mind, be no question but that the proper course to pursue, after careful consideration of the case in consultation, was to empty the uterus of its contents. This could safely be done in the manner indicated by the author. Even when the phthisis was stationary, it was safer to empty the uterus at once than to let the pregnancy proceed to term. When the patient was seen for the first time late in pregnancy, the child being viable, the case was different. Dr. W. Duncan would be guided, under these circumstances, by the condition of the lungs. If phthisis were stationary, though well marked, he would wait till full term had nearly arrived, and then, in order to save the patient all suffering, and the strain on her system consequent on natural delivery, he would dilate the cervix with graduated bougies, followed by the hydrostatic dilators, until it was sufficiently expanded to permit of delivery by the forceps or version, as the case indicated. Full antiseptic precautions would be taken. If, however, the pulmonary disease were markedly advancing, the interests of the mother and child would be best served by effecting delivery in the same manner without delay, instead of waiting until the full term had been reached.—*Br. Med. Jour.*, Jan. 18, 1890.

The Treatment of Ingrowing Toe-Nail.—

"*To the Editor of 'The Medical Analectic and Epitome':*

"As 'Dr. Cotting's Operation for Ingrowing Toe-nail' does not seem to be known to THE ANALECTIC (see vol. vi., No. 49, Dec. 5, 1889, p. 588), why not give a notice of it in a future number? Indications come in from all sides that wherever thoroughly done it is uniformly successful. It certainly is the operation of all others quickest and easiest in performance.

"A READER."

That nothing good may be lost, the Editor cheerfully republishes Dr. B. E. Cotting's original article:

A Few Fragmentary Remarks on the Radical Relief of Infleshed Toe-Nail.—The patient was a young woman, on whom I had performed the same operation on the other great toe, four years before. At that time, a brother, older than herself, received the same treatment for a like ailment. Indeed, some sixteen years ago, I performed four operations simultaneously (on the two sides of the two great toes) for the mother of these patients, making, in all, seven similar operations in the same family.

In each of these seven cases the result was successful in the fullest sense of the term. The ailment was completely eradicated, rever to return. The nails were not injured in the process. They afterwards grew naturally, without pain or hindrance of any kind, soon acquiring normal usefulness. The toes, as usual after the peculiar method employed, were greatly improved in shape and general appearance. Walking also became easy and agreeable, in any kind of boot or shoe.

The method resorted to in all these cases was one devised by myself, more than forty years ago; and, although frequently followed by myself and others here and elsewhere, has never, to my knowledge, failed to effect a radical cure.

It is a very simple procedure: Etherize the patient, unless he object. Remove with the knife the diseased fleshy parts, *together with a large and thick slice* of the healthy adjoining side of the toe. Let the cut begin or go well back, and let it be guided by the edge of the nail, which should be exposed, but need not, nor its matrix, be involved or injured thereby. Dress the wound with lint or absorbent cotton, firmly compressed upon it by a narrow roller-bandage, and cover the whole with a good-sized piece of oiled muslin or silk, neatly secured, in order to prevent any extra oozing of blood.

This is the whole of it. The patient lies abed for a few days, or immediately sits up, or hobbles about, as he pleases, even going to his work at once, if necessary. From the moment of the operation there remains only a clean-cut wound, to heal as other wounds of like dimensions, with less pain or annoyance in it than previously in the disease; while such as there is, rapidly decreasing, soon departs altogether.

This operation, one of the simplest ever devised for this affection, differs from all

the others in its fundamental principle and purpose, namely, the producing of a radical cure by *cicatricial contraction*, and that by means of a wound of sufficiently large extent, in healthy as well as diseased parts. For, as such a wound heals, the remnants of the lateral fleshy nail-furrow, if any remain, together with the soft parts adjoining, are drawn in by the contraction, and, in this manner, are kept away from the edge of the nail. Thus the nail thence after, in its ordinary growth, has nothing to imbed itself in, or even to impinge upon. A return of the affection is thereby put entirely out of the question.—*Boston Med. and Surg. Jour.*, April 7, 1887.

BOOK NOTICE.

Lucas-Championnière (Just) Ovarite—Salpingite—Adhérences; Maladies des Annexes, Lymphangite; Pathogénie, Traitement; Opérations (Ovaritis—Salpingitis—Adhesions; Diseases of the Appendages, Lymphangitis; Pathogeny, Treatment; Operations).

The distinguished author, in this monograph, states that the great number of operations that he has recently done upon the uterus and its appendages have led him to some conclusions quite different from those of the majority of other observers.

In a previous paper upon the anatomy and pathology of the uterine lymphatics the author claims to demonstrate that extension of disease by the lymphatics is more frequent than by the mucous membrane. He also shows that side by side with severe, often mortal, puerperal fever will be commonly observed a benign lymphangitis, which holds a considerable place in the sequelæ of childbed. Hence he concludes that diseases of the lymphatics ought to dominate all the pathology of the region. The author then traces the development of the various inflammatory phenomena of the appendages. He shows how a lesion of the neck, or of the body of the uterus, or even of the vagina, may in the cellular tissue around the uterus lead to the formation of œdema and phlegmon. From his laparotomies, Dr. Lucas-Championnière classifies the cases of disease of the appendages as follows:

1. Salpingitis proper—purulent, tubercular, catarrhal, and with obliteration of tubes.
2. Salpingitis with ovaritis.
3. Ovaritis proper—cystic, purulent, and hemorrhagic.
4. Lateral adhesions, with tube and ovaries normal.

The symptomatology of all these conditions, or of combinations of any two, the author considers practically the same. The characteristic symptom which differentiates these disorders from the uterine diseases proper, is the pain. It is on account of this pain, when nothing cures it, that the patient finally demands operation. This pain is referred to the sides of the uterus and radiates down the thighs; sometimes it is spontaneous, but, above all, is provoked by movement. Walking is difficult, standing is painful. The semi-bent position of the body is the only one which gives relief. But the truly characteristic pain is said to be induced by pressure upon the lateral parts of the uterus. Here a pain is elicited by the touch, which becomes more severe as the hand is withdrawn. The so-called colic of salpingitis, violent tubal contractions, with evacuation of the contents into the uterus, the author considers very rare, except at or near the menstrual periods. The physical signs of the tubal disease will be a tumefaction on the side of the uterus, exquisitely sensitive on pressure. It may have the form of a pear, or other elongated outline. It is separated distinctly from the uterus by a furrow, and is generally different on the two sides. On one side it will be low and posterior, on the other considerably elevated. Often the lesion exists alone on the side corresponding to a fissure of the cervix.

Of all terminations which can supervene, the most favorable is that of the menopause.

When the author comes to treatment, he expresses his unqualified disapproval of certain routine methods. The first of these is vaginal injections, which are considered dangerous and painful, because they irritate the cervix. Secondly, the author condemns dilating the cervix, curetting and cauterizing the uterine cavity, and catheterizing the Fallopian tubes.

The palliative treatment recommended is, first, to assure a very quiet menstrual period, decubitus from the beginning to the end of the flow. Prolonged baths are forbidden; sulphur baths are advised for cases with leucorrhœa. To calm the painful crises, chloral is recommended, reserving as much as possible opium and injections of morphine for cases where operation is inevitable. The bowels must be kept open, and the patient's hygiene carefully regulated. Counter-irritation by means of blisters, but better by the actual cautery, is strongly commended. The cautery should be applied in numerous points over a considerable area, and repeated twice a month. If the cautery is effectual at all, it will be rapidly so. If the cautery fails to relieve the symptoms, there is no resource but operation.

In considering the operative treatment for diseases of the appendages, it is of special interest to consider what can cure the patient while least mutilating her. In a very great number of cases, especially when the adhesions constitute the only lesion, the operator is advised to content himself with detaching them, liberating the epiploön, the intestine, the ovaries, or the tubes, without removing the latter organs. Lucas-Championnière has done this many times with satisfactory results. When one ovary can with any reason be left, it should be. The mutilation of the patient involved by the removal of both tubes and both ovaries is lamented by the author.

The operation, in most cases, arrests the symptoms, but induces frequently a nervous condition, similar to the establishment of the menopause. The author has not found the genital sense diminished by the ablation of the ovaries. His experience with the continuance of menstruation after removal of the ovaries has been that in most cases it ceases; and when it continues, he thinks it is more frequently due to excess of coition than to the leaving of a bit of ovarian stroma to continue its function.

An analysis of seventy-five cases of laparotomy is appended in tabular form, operations done at the Hôpital Saint-Louis in Paris. E. S. B.

THE MEDICAL ANALECTIC AND EPITOME.

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE.

EDITED BY R. W. AMIDON, M.D.

VOL. VII., No. 3. March, 1890. WHOLE No. 155.

THERAPEUTICS.

Moncorvo on the Employment of Strophanthus in Infantile Therapeutics.—In the *Union Méd.* for Jan. 9, 1890, the author sums up his experience in fourteen cases by the following conclusions :

1. Strophanthus, as a cardiac remedy and diuretic, is of great value in infantile therapeutics, because of the energy and promptness of its action, and because of its complete harmlessness in children of all ages.

2. In mitral and tricuspid lesions, with enfeebled action of the heart and scanty urination, the tincture of strophanthus tones up the heart and regulates the rhythm and force of the pulse, acting also, almost without exception, as a diuretic.

3. In the pulmonary or broncho-pulmonary affections of childhood, complicated so frequently by cardiac insufficiency, strophanthus is equally efficacious. This fact has been demonstrated also in cases of asthma in children from nine to eleven years old.

4. The therapeutic effect of strophanthus is not transitory, as in a number of cases it persisted a long time after the cessation of treatment.

5. In no case has the drug seemed to have the slightest effect on the central nervous system or the temperature.

6. The tincture, of a strength of 1 to 20, was always employed, in doses varying, according to the age of the patient, from four to eighteen drops in twenty-four hours.

Laborde on the Effect of Alcohol upon the Stomach, and Other Interesting Findings in an Executed Criminal.—The stomach, which ordinarily contracts when plunged into salt-water, showed no such phenomena in this case. It was completely distended, and showed irregular protrusions. On being opened it was found to contain considerable rum and showed patches of intense vascularity. The paralysis of the organ was evidently due to the alcohol. The lungs showed a general anthracosis, common to prisoners. In the cerebral cortex was a considerable cystic cavity, with meningeal adhesions.—*La Tribune Méd.*, Jan. 9, 1890.

Strahan (S. A. K.) on Choralamide as a Hypnotic, with Special Reference to its Action in the Insane.—The author reports twenty-three cases of different forms of insanity in which he has used choralamide, and he sums up his observations as follows : "1. Choralamide is a very effectual hypnotic. 2. It appears to have no depressing effect whatever on the heart. 3. The dose is about thirty-five to forty-five grains ; but fifty-five grains may be given with safety. 4. It should be administered an hour or an hour and a half before the time sleep is desired. 5. Its action is in some cases deferred so long as three hours, even in cases where it gains prolonged sleep. 6. No ataxic symptoms or headache follow its use. 7. It does not affect the digestive system. 8. It is a very useful and safe hypnotic, and may be given to paralytics whatever their stage. 9. In my opinion it is equal, but in no way superior, to paraldehyde, save that it is much pleasanter to take, and does not impart to the breath any such disagreeable odor as does the latter drug." He gives it in thirty- to fifty-grain doses.—*Lancet*, Feb. 15, 1890.

Harry Toulmin, M.D., considers choralamide much inferior to sulfonal or chloral, and says it possesses no special properties

which warrant its introduction into general use.—*Johns Hopkins Hosp. Bull.*, Feb., 1890.

Valude on a New Specific for Malaria.—Panbotano is the name of the new medicament. A decoction of the bark of a tree by that name is used in strengths varying from 7 per cent. in adults to 3.5 per cent. in children. The tree belongs to the *Leguminosæ* family, and flourishes in certain parts of Europe. Villèjeau has analyzed the drug, and finds a peculiar tannic ingredient in it, but no alkaloid. The botanical name is Calliandra Houstoni. The author has made fifteen personal observations with the drug, and finds that generally the injections of the decoction from two ounces of the bark suffices to cure the case. The author unfortunately gives no details of the physiological action of the drug.—*La France Méd.*, Feb. 21, 1890.

Reynolds (E.) on a Case of Septic Peritonitis Promptly Relieved by Epsom Salts.—The patient was a negro, II.-para, delivered by a midwife of a macerated fœtus and its placenta, the latter removed by traction and in a very ragged condition.

I was not informed of the case until the fourth day, when abdominal pain and distension and increasingly foul lochia had been present for forty-eight hours. I found her with a greatly distended and tympanitic abdomen, internal tenderness, especially well marked over the uterus, lochia externally foul, knees drawn up, face drawn and anxious, pulse small and wiry, spinach vomiting constant and distressing, temperature 104.8°, pulse 144; in short, a typical case of severe and rapid septic peritonitis.

A considerable portion of foul placental tissue was removed by the curette, and an intrauterine douche of 1-4000 corrosive-sublimate solution was given and followed by boiling water. The patient was now so much exhausted that nothing further was done that night, but opiates were ordered in full doses.

The next morning the temperature was 102.2°, pulse 133; patient looking worse; other conditions unchanged. She was ordered to take epsom salts, one drachm evey two hours. The afternoon temperature was 104°, pulse 134; vomiting still constant; abdomen even more tympanitic; no motion as yet, but "Feels as if there would be soon." That night she had ten to twelve copious watery dejections; and in the morning, though the temperature was 102°, the pulse had fallen to 127, soft and regular; the abdomen was flat and non-tympanitic; the tenderness was almost gone; the vomiting had stopped, and the patient looked another woman. Under a continued, though less constant, use of salts, the temperature remained decreasingly above normal for a week, but the pulse was good, the vomiting never returned, and the patient made a steady and rather rapid convalescence.—*Boston Med. and Surg. Jour.*, March 13, 1890.

Hinsdale (G.) on the Solvents for Fæces.—In an article on "Electricity in a case of fæcal impaction" the author adds notes on the above subject.

The conclusion from these trials would seem to indicate that an alkaline solution, like lime water, or solutions of Rochelle salt, would be most likely to soften scybala; that oils and glycerine harden them, and that a weak acid solution chiefly affects the coloring matter.—*Med. News*, March 8, 1890.

Pignol on Tracheal Injections of Naphthol in Pneumonia.—The author employs a .02 per-cent. solution of naphthol and injects 200 to 350 c.c. at a sitting. These injections are well tolerated, and have caused no accident. Patients confess an immediate diminution of dyspnœa, and soon râles appear where there was before only bronchial breathing. In one case the fever fell after the injection, although it was given early in the disease. Other patients showed great improvement. The trachea is punctured with a needle, and the fluid is allowed to trickle in drop by drop for a half hour.—*La Tribune Méd.*, Jan. 9, 1890.

Bismuth Salts and the Odor of Garlic.—The cause of the odor of garlic occasionally communicated to the breath of patients who are taking preparations of bismuth is said to be the presence of the metal tellurium as an impurity. The fact that tellurium gives this odor to the breath was first noticed by Sir James Simpson, who when making trials of the salts of cerium also experimented upon tellurium. He reports a case of a divinity student who inadvertently got a dose of tellurium which was followed by the evolution of such a persistent odor of garlic that for the remainder of the session the patient had to

sit apart from his fellows. That specimens of bismuth preparations, which caused this peculiar odor of breath, contained tellurium was established in 1875. The British Pharmacopæia guards against this impurity by giving a special test for its detection in bismuthum purificatum. — *Brit. Med. Jour.*, March 1, 1890.

Turpentine in Typhoid Fever.— Dr. H. C. Wood advises a return of the turpentine treatment of typhoid fever as practised by Dr. G. B. Wood. He begins its use about the twelfth to the fifteenth day, thinks it lessens the tendency to hemorrhage, and ameliorates other symptoms due to the local lesions.

His formula is:

℞.—Oil of cloves . . . . . gtt. vj.
Oil of turpentine . . . . f ʒ jss.
Glycerine, Mucil. of acacia . . . āā f ʒ ss.
Syrup, Water . . . āā q. s. ad f ʒ iij.—M.

SIG.—Dessertspoonful every three hours during the day.

—*Med. News*, March 8, 1890.

Licorish (R. F.) on the Value of Absolute Rest and Starvation in the Early Stages of Typhoid Fever.— The author concludes that typhoid fever may be aborted, but the patient must be seen and treatment begun within the first few days of its onset—the initial chill. The chief aim should be to restore the appetite, which is best done by a deprivation of food until nature demands it. This procedure is safe if a horizontal posture be maintained. After a normal temperature has been attained, one week should elapse before the patient should sit up, and ten days before small quantities of solid food should be given.—*Med. Record*, March 8, 1890.

[Would not the same end be more speedily attained by a return to the old method of venesection in febrile ailments, *i. e.*, the abstraction of a small amount of blood early in the disease?—EDITOR.]

Grehaut (N.) on Poisoning by Absorption of Prussic Acid through the Eye.—The experimenter prevented inhalation of the poison by connecting the trachea of the animal with a long tube. He then injected into the eye 2 c.c. of a 1 to 4 dilution of the drug. In twenty-five seconds the animal became agitated, the respiratory movements being first accelerated and then slowed. A minute later a second injection of 3 c.c. of the same solution was made. In seven seconds the respiratory movements became slow and the respiratory curves showed large plateaux. Fifty-one seconds after the second injection the respiratory acts became infrequent and of a lethal character, and the animal died.

These experiments showed that prussic acid can be absorbed in sufficient amount by the eyes to kill in from two to three minutes, being taken up by the blood and in this way stopping respiratory and cardiac movements, direct absorption by the lungs being completely avoided.—*La Tribune Méd.*, Feb. 6, 1890.

Cerna (D.) on Some Cases Treated with Iodol.—CASE I.: Male, fifty-five, grocer. Phagedenic ulcer, lower third left leg, of years' standing. All previous treatment had failed. Ulcer cleansed with bichloride solution, dusted with powdered iodol, covered with absorbent cotton pack, and leg bandaged from foot to knee. Odor disappeared, discharge lessened, and cicatrization commenced. Cure in twenty-eight days.

CASE II.: Woman, fifty, housewife. Scrofulous, possibly syphilitic taint. Ulcer on each leg, round, excavated, hard, red, ragged edges, granulations ugly, discharge abundant, white, viscid, and with bad odor. No treatment had benefited them. One ulcer was treated with iodoform and one with iodol. The latter healed in three weeks, the former had improved scarcely at all, and iodol was substituted, with cure in two weeks.

CASE III.: Like the former, only a distinct syphilitic history could be obtained. KI internally could not be borne. Iodoform failed locally. Iodol cured in three weeks.

CASE IV.: Carpenter, forty-five. Tubercular syphilide of left ear and end of nose. Could not stand KI. Iodol resorted to in doses of 3 gr. three times a day. Cure in six weeks. Slight diarrhœa, ceased when drug was stopped. No local treatment.

CASE V.: Laborer, thirty-eight. Phagedenic, syphilitic ulcer of fauces. A perfect wreck. Ordinary specific treatment produced iodism and ptyalism. Iodol locally and internally. Discharged cured in three months.

CASE VI.: Farmer, thirty-eight, diabetic. Milk diet and 6 grs. iodol daily. In two months sugar left the urine and patient was well.

Internally the author has given as much as twenty grains daily. Externally he applies it in powder, in solution in ether or alcohol, or in an ointment. — *Med. News*, March 8, 1890.

Montagnon on the Treatment of Ingrowing Toe-Nail with Indigo Powder.—A man of twenty-five had, in spite of various treatment, suffered seven years from ingrowing toe-nail.

The nail was raised by fine threads of lint, and the ulcerated surface was dressed with powdered indigo.

The author claims that this pathological condition depends on a disease of the soft parts, and is not the fault of the nail. Upon this hypothesis an astringent, tonic substance like indigo so modifies the tissues as to produce cicatrization.

Chaussignat, according to the editor, advocated the same treatment in 1887.—*Loire Méd.*, Jan. 15, 1890, in *Le Poitou Méd.*, Feb., 1890.

Caudwell (H.) on Glycerine as a Dressing in Necrosis.—G. P., a pale, unhealthy lad, aged fifteen. On admission the anterior aspect of left tibia for a space of eight inches was riddled with twelve sinuses connected with necrosed bone, and involving nearly whole length of tibia, except articular extremities.

April 8th.—Patient chloroformed, and by help of chisel, gouge, and forceps, sequestra were removed till little more than shell of tibia was left, with a large cavity of about nine inches in length. This was at first stuffed with carbolic lint, but at the next dressing, when oozing was controlled, the cavity was filled with ordinary glycerine; then covered with pieces of protective and bandage, and limb raised. This treatment was continued till July 12th, when the healing process was nearly completed.

July 20th.—Patient discharged, leg quite healed.

S. E., girl, aged seven. Strumous family history; pale and emaciated on admittance. Over anterior and lower two thirds of left tibia were five sinuses connected with necrosis of the bone, following acute periostitis.

May 2d.—Under chloroform the necrosed portions of the shaft of the tibia, together with some new bone formed around the sequestrum, were freely removed, leaving large cavity. At second dressing this cavity was treated with glycerine as in previous case, and continued till cavity was too shallow to hold the fluid.

July 30th.—Completely healed, with exception of one small sinus, probably connected with spicule of necrosed bone.

In both cases the reparative process was very rapid; the granulations florid and redundant, under the stimulating influence of the glycerine, the wounds quite healthy, and moreover, what is a great advantage with young patients, the dressing was absolutely painless as contrasted with the agony caused by plugging cavities in bones. Possibly had the glycerine been impregnated with carbolic or boracic acid, the results might have been still more satisfactory.—*Brit. Med. Jour.*, March 1, 1890.

Andrew (J. G.) on a Case of Obstinate Vomiting Cured by Skim Milk and Arsenic.—A girl of nine had vomited daily for several months, of late after each meal, with little pain or inconvenience. Nothing but frothy yellow food was vomited. After vomiting she felt hungry. Bowels were rather loose; tongue clean.

Abdomen and chest, on examination, seemed normal, and child appeared healthy. The child's mother had a delicate stomach.

For the treatment of the condition in the child numerous remedies were tried, and alterations and suggestions made in her diet. Bismuth, rhubarb, sodium, and other stomachic sedatives were tried, but without much help. *The diet was then limited entirely to skim milk, and two drops of liq. arsenicalis* were given thrice daily after the milk. The vomiting immediately ceased, and several days after she managed to retain a little beef tea and dry toast, and now feels as if she were able to take the round of the house.—*Glasgow Med. Jour.*, March, 1890.

Drake (F. N.) on Local Application of Sulphur in the Treatment of Diphtheria.—In the local treatment of diphtheria situated *above* the larynx, I find it of great advantage to preserve the false membrane as long as it will remain in its place. The diphtheritic membrane answers admirably, after having first applied a non-irritating disinfectant over it, to retain the medicament used and to *dress* the diphtheritic spots in the mucous membrane beneath.

The false membrane may be disinfected by irrigating it with a solution of any of the soluble disinfectants. The medicament afterward applied to the diseased areas should be slow of solution or insoluble. I have found washed sulphur to act well for

this purpose. It may be insufflated, or, as I prefer, applied with a wad of absorbent cotton wound on the end of a stick, or with a large camel's-hair pencil. If well packed into the meshes of the membrane, from three to five applications in the twenty-four hours are sufficient; twice during twenty-four hours will answer in mild cases. Patients old enough to express themselves frequently assert, soon after the sulphur has been applied, that their throats feel better. Probably the sulphur, while in the meshes of the moist, warm, false membrane, takes up oxygen and sets free sulphurous acid, thus keeping the part in constant contact with this powerful germicide.—*Med. News*, March 8, 1890.

Vidal on Ipecac and Antimony in Hæmoptysis.—M. Vidal recommends treating pulmonary hæmoptysis in phthisical patients with ipecacuanha and antimony, or kermes (oxydum stibii sulphuratum rubrum), in small doses every ten minutes; if this does not completely arrest the hæmoptysis, M. Vidal counsels applying Gunod's cupping glasses or ligating a limb. When fever is present, two grammes of ergot of rye and one gramme of sulphate of quinine divided in four doses, to be taken every three hours, M. Vidal has found successful, but condemns the use of iron or arsenic, generally considered good in treating hemorrhage.—*Brit. Med. Jour.*, Dec. 14, 1889.

Krauss (W. C.) on Acute Belladonna Poisoning; Profuse Epistaxis; Recovery.—A so-styled nurse visited a patient with mumps and strongly insisted on her taking belladonna. "Oil of belladonna" was forthwith procured at a neighboring drug store, and, after some manipulation, was administered. After several doses the patient felt her heart beating rapidly, the temples swell, accompanied with strange psychical disturbances, and excessive dryness of the mouth. For a few moments she was in ecstasy, "never felt happier in her life," began to laugh and sing, and tried to leave the bed. Soon afterward her head became exceedingly heavy and dizzy, with painful pulsation at the vertex, perspiration and incoördination followed. An attendant present says her eyes were glassy and had a most peculiar expression, her face was extremely congested, and her delirium seemed to grow continually worse. No physician was summoned. While suddenly turning in bed, her nose began to bleed profusely, *the blood* seeming to leave the nostrils in jets,—something after the manner of projectile vomiting. After three towels had been saturated with blood the hemorrhage ceased, and the patient felt instantaneous relief from all symptoms, save a dull, heavy headache, which persisted several days.

The epistaxis occurring, as it did, at the acme of the attack, and the instantaneous relief it afforded, might suggest the employment of venesection as an antagonistic measure in such cases.—*Buffalo Med. and Surg. Jour.*, March, 1890.

Russell (J. S. R.) and Taylor (J.) on Suspension in Ataxia.—This is a second series of cases reported by the authors. They comprise eighteen cases of locomotor ataxia, and one case each of paralysis agitans, disseminated sclerosis, and ataxic paraplegia treated at the National Hospital for the Paralyzed and Epileptic.

Their experience is not encouraging. Of the ataxics one became slightly less ataxic but quite unable to walk alone; other symptoms unchanged; one had less abdominal distension, otherwise no change; one thinks he walks a little better; no change apparent; one improved considerably in ability to walk, but relapsed in the last week of treatment; one improved until he had thirty suspensions, when he remained stationary; twelve cases showed no *change;* one case was made distinctly worse. The case of ataxic paraplegia considers himself better; signs and symptoms remain unchanged; the case of paralysis improved; the case of disseminated sclerosis showed no change.

No accidents occurred in connection with the treatment. One or two complained of pain in the jaws, and one or two of pain at the bottom of the back, and a similar number of pain at the back of the neck.

In no case were ocular symptoms relieved.—*Lancet*, Feb. 1, 1890.

The Treatment by Suspension.—The literature on the treatment of locomotor ataxy and other degenerative diseases of the spinal cord by suspension is already voluminous, and the views held as to the mechanism and the therapeutical value of the treatment are extremely contradictory. The most valuable of the recent contributions to the subject is one by Dr. Cagney on the Mechanism of Suspension, which he read

before the Royal Medical and Chirurgical Society on the 14th of January, and which was discussed last Tuesday evening. It was hinted by Charcot, and assumed by his disciples that the good effects observed were due to the forcible stretching of the spinal cord and nerve roots. By means of carefully devised experiments and accurate measurements both on the living body and on the cadaver, Dr. Cagney is able to show that the effect of suspension is to straighten the curves of the spinal column, in this way producing a total shortening of the spinal canal. This is well marked in the cadaver, and is probably greater in the living subject, owing to involuntary muscular contraction. In his inaugural address at the University of Aberdeen Professor R. W. Reid stated that his measurements had led him to the same conclusion. The effect is most marked in the dorsal curve, where distinct relaxation of the cord can be seen to take place. In the cervical region there is slight stretching of the dura mater, which is probably not sufficient to influence the spinal cord. Whatever good, therefore, has resulted from the treatment cannot be regarded as due to stretching of the cord. Dr. Cagney offers the suggestion that the apparent good effects are due to the breaking-down of adhesions between the fibres, and to the removing of impediments to the circulation, both of which explanations are entirely hypothetical and not altogether probable. Since the effect on the cervical region of the cord is practically *nil*, and suspension from the head is dangerous and inconvenient, he submits that the best results might be expected from suspension from the armpits only, or from suitable gymnastic movements. The main points in the discussion related to the dangers and discomforts of the treatment. Several of the speakers mentioned cases where vomiting and syncope had been set up. This occurs even with healthy persons. One of the speakers who had been suspended by Dr. Cagney for one minute, although in perfect health at the time, experienced great pain, and fainted on being let down, and continued in a fainting condition for an hour. In the carefully recorded series of cases reported by Drs. Taylor and Russell in *The Lancet* of October 19th, 1889, epigastric pain, nausea, and syncope were produced by the treatment in several individuals, and they were apparently the cause of death in the case recorded by Dr. Borsari of Modena. It was observed by Dr. Cagney that the splanchnics could be seen to stretch in the process; and he suggests, with great probability, that it is to this stretching that we must ascribe these accidents. If this be so, however, suspension from the axillæ alone will be as likely to cause them as the combined cervico-axillary method usually employed. The question of the therepeutical value of the practice was not touched on by the paper. We understand that it will be the subject of the discussion at the forthcoming meeting of the Neurological Society, and for the present we postpone any remarks on that subject.—*Lancet*, Feb. 1, 1890.

MEDICINE AND PATHOLOGY.

Binet (P.) and Prévost (J. L.) on Experimental Study of Lead Poisoning.—These experimenters found that the subcutaneous or intraperitoneal insertion of metallic lead produced no tonic phenomena. The intravenous injections of peptonized salts of lead often produced rapid death. Subcutaneous injections of the same frequently produced abscesses.

Injections into the stomach or the admixture of a certain amount in the daily food and drink produced poisoning of long duration, extending over months or more than a year.

Animals treated in the latter way continually lost flesh, losing generally before their death ⅓ of their weight.

The red blood-globules became less numerous and were altered in their structure without any increase in the number of white blood-globules.

Albuminuria was generally neither constant nor abundant. Nervous phenomena such as paralysis, aphonia, loss of reflexes, anæsthesiæ were seen. Convulsions were very infrequent and of doubtful origin. The paralysis disappeared without treatment.

From an anatomical point of view it was noted that the kidneys uniformly became grayish, contracted, often cystic. Under the microscope, the nephritis and calcareous granules described by Charcot and Gombault were demonstrated.

Fatty degeneration of the liver was frequently seen and quite often a pericarditis and sometimes a granulo-fatty degenera-

tion of the myocardium. The segmentary, periaxial lesion of the peripheral nerves, described by Gombault, was present, the spinal nerve-roots, as pointed out by M. and Mme. Dejerine, being rarely affected.

Chemical examinations revealed the fact that the lead accumulated principally in the kidneys. In the bones also it was very abundant, seemingly fixed under the form of a phosphate. Less lead accumulated in the liver than in the kidneys. In the muscles, spleen, central nervous system, eyes, lungs, heart, pancreas, genital organs, and blood, the poison was present in small amounts if at all. Embryos or newly born young only once showed traces of lead. A voluminous ovarian cyst, which developed in a rat subjected to experiment, contained a great deal of lead, particularly in its walls.

As a general thing little lead is eliminated in the urine, more when it is albiminous. A considerable amount of lead is eliminated by the bile, very little if any by the saliva.

After the free administration of the iodide of potassium and the ammonia salts great quantities of lead were still found in the kidneys.—*L' Union Méd.*, Jan. 7, 1890.

Brown (J.) on Unsuspected Lead Poisoning in Children.—Although the literature of plumbism is so voluminous, yet very little has been written as it regards the influence of lead in children. In no work specially devoted to diseases of children can any reference to plumbism be found. For about three years I have devoted considerable attention to plumbism due to water contamination from lead service pipes. In 1888 my attention was drawn to the fact that young children may suffer from plumbism—this is only what might be expected. By careful research I found about a dozen cases recorded, but nothing very striking in connection with the reports.

I am not aware that the blue line in the gums has been observed in children during the first dentition; when present it is a pathognomonic symptom of plumbism. Its absence does not prove the contrary. In children tartar is rarely present compared with adults. This is the reason why the blue line is so seldom found in children. I have notes of four children under five years, in whom the blue line was present; also eighteen over five and under ten years; total under ten years, twenty-two; ten and under fifteen years, twenty cases. Besides these forty-two in which the blue line was present, there were others who were suffering from plumbism in whom no blue line could be found, because the teeth were kept free from tartar. In *Brain*, April, 1878, Dr. Buzzard reports a case of well-marked lead palsy in which the blue line was absent, due, as Dr. Buzzard believes, to the exceeding care which the patient had taken to keep the teeth clean. In adults the blue line is most commonly observed in the gums of the incisors and molars. In children the gums of the incisors are often free, but the blue line may be observed on the gums of the molars. It is often associated with a peculiar form of caries, which attacks the crowns of the molar teeth at their junction with the fang. The surface or cusps of the teeth are sound; there is a cavity about 2 millimetres in diameter, which offers a nidus for food to lodge in. The food is decomposed probably by saprophytes and sulphuretted hydrogen is formed which combines with the albuminate of lead, and is deposited as the sulphide in the capillaries of the papillæ of the gums. The nature and mode of origin of the blue line in the gums are given in the *Med.-Chirurgical Journal*, vol. lix., 1876, page 327, by the late Dr. Fagge. Having made microscopical examination of the blue line I can confirm his views. The line is not continuous, but consists of a series of blackish-brown dots, full of minute granules. Each dot is distinct from its fellow.

In twenty-one adults I observed blue patches on the mucous membrane inside the lips and cheeks. In every case it was opposite the deposit of tartar. Dr. Dobie, of Chester, reported two cases in which there were blue patches on the mucous membrane in adults,[1] and he thought it was due to abrasion of the cheeks. From my observations of the twenty-one cases referred to, I am convinced that it is due to the tartar on the teeth. The following is an interesting case. A child, aged six years, had the mucous membrane deeply pigmented. The first lower molar on the right was displaced; the fang projecting against the cheek had caused an ulcer which was free from blue pigmentation, but a blue line was on the gums, proving that abrasion is not sufficient to cause pigmentation.

[1] *Journal*, vol. l., 1886, p. 29.

Children are not so susceptible to the toxic influence of lead as persons between the ages of fifteen and fifty years. Above and below those ages lead rarely produces the more severe symptoms of plumbism. In children, mercury, antimony, and arsenic are known to be tolerated in comparatively large doses. This tolerance of lead in young children is probably due to lead being a nerve poison, and acts primarily on the nuclei of the nerve cells, especially the motor nerve cells. It is noteworthy how slight the symptoms of plumbism are in children in families where the adult members suffer from the most severe forms of the disease. In one house the father and mother were both suffering from lead palsy, colic, constipation, absence of the knee-jerk. The mother had saturnine epilepsy. Two children, aged seven and nine years, had the dark blue line; neither suffered from any symptoms calling for treatment. The water used for dietetic purposes by this family was largely polluted with lead. The chief symptoms of plumbism in children are constipation, colic, frontal headache, anæmia, absence of knee-jerk—this is not constant. In one case it was excessive. There was only one severe case out of forty-two; this was a child aged four years. There was dark blue on the gums, severe colic, obstinate constipation, difficult and painful micturition, marked anæmia, tremor of the legs, which was followed by paresis, and ultimately paralysis. The father was suffering from plumbism; he had colic, constipation, epileptic convulsions, loss of vision, paralysis of arms, paresis of legs. The mother of the child was also very ill, but had no lead palsy. On analysis the water supply contained 1½ grains of lead per gallon. Under treatment the child made a slow recovery. The symptoms of plumbism in children are usually so slight that they may be easily overlooked. Anæmia is the most common symptom, and is generally well marked.—*Brit. Med. Jour.*, Jan. 25, 1890.

Rosenbery (H. L.) on Erysipelas as a Cause of Death in Typhoid Fever.—A woman of twenty-five had been suffering from typhoid-fever for fourteen days. On the fourteenth day her morning temperature was 104.4 F.; pulse 124, and respiration 30. In answer to the inquiry if any thing hurt her, she said she was well except her arm, which was paining her very much. She bared the arm, and there was a little blue spot the size of a penny, surrounded by a deep red circle the size of a half dollar. This seemed insufficient to account for the aggravation of all the symptoms, as her bowels were no worse. She asked what it was, and I told her it was certainly erysipelas. While I was still looking at her arm another spot the size of a silver dollar appeared above the first spot, over the insertion of the deltoid. The two spots soon coalesced. It spread with such rapidity that while I was there it had involved nearly the whole of the arm.

She died at 6 P.M. I saw her after death and the eruptions had spread so as to cover the entire surface of both arms, chest, face, and head. The death of the fœtus occurred in the morning of the day she died, before my visit.

In substantiation of the diagnosis of typhoid fever, I may say that a sister of Mrs. L. died a week later of typhoid fever, and two brothers and a sister recovered from very severe attacks.—*Columbus Med. Jour.*, January, 1890.

Ollivier on Nervous Troubles after Typhoid Fever.—In the case of a girl of five, after recovering from a light course of typhoid fever, the author discovered a loss of sensibility to touch, pain, and temperature over the entire cutaneous and mucous surfaces. The tendon reflexes were diminished and even abolished in the lower extremities. Complete recovery took place in twelve days.

In another case he saw complete anæsthesia in the course and distribution of the left brachial plexus.

He has seen hyperæsthesia, under the same conditions, in a child so severe that the weight of the bedclothing was unsupportable to the trunk and limbs. This condition lasted only fifteen days. In one case the hyperæsthesia was confined to the dorsum of the foot; in another to the sole of the foot.

These sensory disturbances are only seen during convalescence, among young subjects of both sexes, are often discovered accidentally, and the prognosis is always good.—*Jour. de Méd. et de Chir. Prat.*, January, 1890.

Malgat on an Aphasic Form of Pernicious Fever.—Under this head the author narrates three cases of aphasia, appearing suddenly and disappearing at the

end of some hours to reappear the next day at the same time and again disappear under the influence of the sulphate of quinine. This symptom was preceded by a visual disturbance, consisting of a sensation of transparent rods floating in the air. Two of the patients had previously inhabited malarious countries and had had attacks of fever; the third patient was a woman with chronic peritonitis, who died in three days in a state of coma. The author attributed this affection to a pernicious form of malaria.—*Nice-Médical*, December, 1890.

Hill on Aural Complications in Acute Specific Fevers.—The author remarks that more than fifty per cent. of the cases of chronic ear-diseases commencing in early life were traceable to the aural complications of fevers. The somewhat higher percentage observed before Meyer demonstrated the importance of naso-pharyngeal obstructions were doubtless due to the fact that the exanthemata are potent exciting factors in the induction of adenoid overgrowth of the pharyngeal tonsil in those of "lymphatic temperament," and indirectly of ear lesions, and cases now rightly attributed to post-exanthematous "adenoid growths" were formerly classed amongst the direct aural complications of acute fevers. After detailing English and foreign statistics dealing with the frequency of ear symptoms in the course of scarlet-fever, measles, whooping-cough, mumps, and other states, the destructive nature of these complications on the membrana tympani and ossicula, if untreated at the time, was pointed out and contrasted with the rapid recovery from perforation, discharges, and impairment of function when similar conditions were not neglected, but treated *secundum artem*. In measles, pneumonia, and pertussis, in which the inflammation spread up the Eustachian tube, the otitis could often be prevented, and nearly always arrested or limited to the non-suppurative variety by appropriate naso-pharyngeal and inflation treatment. If neglected, suppuration of the middle ear resulted from tubal obstruction and accumulation and retention of tympanic secretion; the tendency to this acute suppurative stage was more marked when the middle ear became involved in scarlet-fever, small-pox, and diphtheria, and if unrelieved by immediate incision of the membrane on the onset of pain or evidence of intra-tympanic accumulations, the destructive processes above alluded to resulted, and frequently also involved the labyrinth. If on establishing proper drainage, together with frequent syringing of the meatus with antiseptic lotions and inflation by the tube, the pain was unrelieved, the application of leeches or incision for mastoid inflammation, and of Leiter's continuous cold coil for less limited pain, was recommended. The use of internal anodynes also afforded relief in some instances; but if a thorough otological examination was not made and appropriate surgical measures adopted, the mere relief of pain often lulled to false security, whilst irreparable destruction was going on in the delicate auditory organ. In cerebro-spinal fever, mumps occasionally, and in typhus, the labyrinth was usually primarily involved. Such a complication might be aggravated by such remedies as salicine or quinine, which were best avoided in acute aural disease; iodide of sodium internally, or pilocarpine hypodermically, being the most serviceable drugs. In conclusion, Dr. Hill pleaded that aural symptoms should invariably be looked for early in the course of fevers, in the same way that the thoracic and renal organs were watched. With appropriate nasal and pharyngeal treatment, otitis could often be prevented or mitigated in severity. If enlarged tonsils or adenoid growths interfered with treatment they should be removed. Whilst anodynes were indicated for pain, other treatment, including early incision of the tympanic membrane, was necessary in order to limit rapidly destructive suppurative processes in the middle ear and labyrinth.—*Lancet*, Jan. 11, 1890.

Dantz (E.) on Successful Laparotomy in a Case of Suppurative Peritonitis in a Child of Seven.—An orphan girl of seven, of previous good health, began to complain, about April 25th, of pains in the stomach and head, and loss of appetite. In spite of appropriate and energetic treatment, general suppurative peritonitis, with tremendous gaseous distension of the abdomen developed. Over six quarts of pus were withdrawn with a trocar, but the child was being slowly consumed by the high fever and inanition when, on June 23d, an operation was decided on and performed. Much gas and a good deal of pus escaped from the abdominal wound, the peritoneal cavity was flushed out with a warm borated

solution until the fluid returned clear, a drainage tube inserted, and the wound closed up. Convalescence followed at once without interruption, and was complete in fourteen days.—*Jour. de Méd. de Chir. et de Phar.*, Dec. 20, 1889.

The Septic Germs in Peritonitis.—We have recently had occasion to refer to the distinctions between septic and simple peritonitis, and to note how Dr. Bumm, of Würzburg, has shown that the streptococcus is most deadly when taken from peritoneal fluid in the early stage of puerperal peritonitis. Dr. Orth has shown that the septic influence of undoubtedly septic germs is more strongly modified by certain pathological conditions than even Dr. Bumm's researches would lead us to suppose. Although strong infusions of "pure cultures" of staphylococcus pyogenes aureus or streptococcus pyogenes injected into the peritoneal cavity of rats, etc., failed to cause any lesion of the peritoneum, the same amount of germs caused deadly results when mixed with material which could not be absorbed, or which could only be absorbed slowly. Disease of the peritoneum, already existing, favored the action of the germs; in ascitic animals a very small quantity of staphylococcus caused septic peritonitis. The same result followed when any intra-abdominal structure was wounded, even when a piece of mesentery was excised, or a spot cauterized. When a piece of gut was ligatured, with precautions, for six hours, no bad results followed, but when ligatured for a shorter period with consecutive injection of staphylococcus fatal peritonitis followed. These experiments show the grave consequences which may follow the introduction of germs into the peritoneum after abdominal operations, especially if that serous cavity is not kept clear of effused fluids and solid particles. Rapidly fatal peritonitis followed the injection of staphylococci into the blood, or into a compound-fracture wound in cases where the intestine was ligatured.—*Brit. Med. Jour.*, March 1, 1890.

Hunter (W.) on the Pathology of Duodenitis after Burns.—In 1842 Mr. Curling drew attention to it in a paper before the Royal Medical and Chirurgical Society. Since then a considerable number of cases had been recorded by various observers, and now there was a widespread belief in the existence of some connection between the injury to the skin and the duodenal affection; but up to the present time no satisfactory explanation of its nature had been given. Mr. Curling's suggestion that the suppression of the excretory functions of large tracts of skin caused increased action with consequent ulceration of Brunner's glands had no physiological foundation, and Dr. Brown-Séquard's, that it was due to some disturbance of the sympathetic system, was a mere euphemism for ignorance. The author then mentioned that Dr. Wilks had collected a series of twelve cases which gave no corroboration to Mr. Curling's suggestion, and Mr. MacCarthy had only observed the duodenal lesions twice in eight years in the post-mortem room of the London Hospital. The author considered that the relation might be explained by some experiments which he had recently conducted, in which he found that, after injecting into a dog from three to five grammes of toluylendiamene subcutaneously and then killing the animal some three to seven days later, there was intense duodenitis, caused by the irritation of the poison excreted in the bile. He then described in detail some of the experiments; in one in which the animal was killed seven days after the insertion of the drug, the stomach was empty and its mucous membrane normal, but the mucous and submucous coats of the duodenum at a level of eight inches beyond the pylorus were so congested that the lumen of the gut was almost blocked and was nearly filled by inflammatory mucus, and many of the follicles in the small intestine as far down as the lower end of the ileum were also congested. In another experiment the dog was killed three days after the insertion of the poison, and there were what looked to be three or four small ulcers in the duodenum, together with congestion of the whole intestinal tract beyond. On examining the ulcers microscopically there was found to be no actual loss of substance, the appearance being due to the congestion of the mucous and submucous coats around follicles in the wall of the intestine. There might be one or more of these ulcerated-looking spots or merely simple congestion. In some cases of death after burns congestion had been described as being confined to the neighborhood of the opening of the bile and pancreatic ducts, and in others it had extended as far as the lower end of the ileum, and exactly similar con-

ditions had been present in the experiments with toluylendiamene. If one assumed an analogy between the result produced by the injection of the drug toluylendiamene and the pathological condition sometimes found in the duodenum after death from burns, and which occurred within ten days of the burning owing to perforation of the duodenum and subsequent peritonitis, or from ulceration through the wall of an artery, one might conclude that congestion was always present but only very rarely proceeded to ulceration, and this would explain the difference between Mr. Curling's and Dr. Wilks' conclusions, as the latter's cases related to death soon after the burn, and in the former's death did not occur until a later period. The author then showed that there was another very striking similarity between the action on the blood of the drug toluylendiamene and the changes caused by burns. In both there was marked changes in the blood, and in both hæmoglobinuria had been known to occur. These results were due probably in the case of burns partly to the high temperature and partly to the absorption of the disintegrated products by the blood. He had found that toluylendiamene began to be excreted in the bile in an hour and a half to two hours after subcutaneous injection, but it was not all excreted by this channel, and a portion was probably broken up in the body and the products excreted in the urine. The result produced by the drug depended upon the animal experimented upon. In dogs it produced jaundice without hæmoglobinuria, in cats hæmoglobinuria but no jaundice, and in rabbits neither jaundice nor hæmoglobinuria, facts which showed that results obtained experimentally on animals could not be transferred directly to human physiology or pathology, and he summed up by suggesting that the changes when present in the duodenum, both after burns and after toluylendiamene poisoning were due to the excretion of irritant poisons from the body in the bile.—*Brit. Med. Jour.*, Jan. 11, 1890.

The Effect of Licensing Prostitution upon Venereal Disease.—Commenge, in the ten years from 1878 to 1887, has arranged the sick prostitutes coming under his notice in three categories:

1st. Those registered either in houses or by card;

2d. Those registered but often arrested;

3d. Those unregistered (*i.e.*, not licensed).

	No. of Visits.	Visits for syphilis.	Visits for non-syphilitic venereal disease.	Visits for the itch.
Women registered by card	305,799	.312 %	.306 %	.036 %
Women in registered houses	503,712	.270 %	.252 %	.030 %
Women arrested	76,740	2.396 %	1.146 %	.406 %
Unregistered women	27,041	16.6 %	13.4 %	1.9 %

This shows the enormous prevalence of syphilis among women not submitting to regulation.

M. Commenge also arranges his statistics in another way, as follows:

	Women visited.	Syphilitic women.	Non-syphilitic venereal women.	Women with the itch.
Women registered by card	13,048	953 = 7.30 %	936 = 7.16 %	114 = 0.85 %
Women in registered houses	10,494	1,361 = 12 %	1,272 = 13.12 %	146 = 1.32 %
Women not conforming to police regulations	27,041	4,513 = 16.69 %	3,640 = 13.41 %	530 = 0.95 %

These figures clearly show the need of the regulation of prostitution.—*L'Union Méd.*, Jan. 9, 1890.

Moret on Precocious Cerebral Syphilis.—A man of forty entered the hospital Oct. 5, 1889 for a left hemiplegia which came on suddenly in the evening without loss of consciousness. Aside from several attacks of lead colic the man had been healthy up to two months of the time of his admission. At that time he contracted a large indurated chancre of the penis accompanied by indolent inguinal buboes. The patient neglected his trouble and in a month began to notice embarrassment and heaviness of the limbs. Toward evening his head ached and at night he was delirious.

Such was his general condition up to Oct. 5th, when, after working all day, he noticed a numbness and pricking sensation on the left side of the body, principally in the hands and fingers. An hour afterwards he was seized with contracture in the same parts, lasting ten minutes, with terrible suffering but without loss of consciousness. This attack of Jacksonian epilepsy termi-

nated in paralysis of the left arm. Sensibility of the entire body was preserved with a slight difference in favor of the right side. The limbs on the right side could be moved but with difficulty. The left arm was powerless while the left leg could be moved slightly and with great effort. Repeated attacks of convulsions, without loss of consciousness, occurred during the day until about eight o'clock on the evening of the 6th, when the patient had a general convulsion with very acute pain. After this attack the patient became comatose, in which condition he died at seven the next morning.

On post-mortem examination the cerebral membranes were much congested ; the vessels, the veins in particular, were much dilated, gorged with black blood, over the convexity of the hemispheres, more marked on the right side. A vein in the occipital region on the right side of the longitudinal fissure had ruptured, and at this point was a clot of blood several centimetres long, occupying the posterior third of the fissure. —*Union Méd. du Nord-Est.*, Jan., 1890.

Dennetières on Exophthalmic Goitre and Œdema of the Glottis, with Gumma of the Cricoid Cartilage.—The patient was a woman, who, at the age of 28, began to have palpitation and prominence of the eyes. When 34 years of age she was seized with pain in the throat and difficult respiration. She was admitted to the hospital on the 5th of November, saying that for ten months her throat had troubled her, having a hoarseness and incessant cough, with dysphagia. She had pronounced exophthalmos and hypertrophy of the thyroid gland, palpitations, and tachycardia ; pulse, 180 ; a non-hypertrophied heart ; voice and cough were harsh ; respiration, 38 ; slight substernal retraction ; greatly diminished vesicular murmur ; normal sonorousness. No cyanosis nor lowering of temperature, scanty and albuminous urine. An ordinary examination of the throat revealed nothing, and it was thought to be a case of suffocative goitre. The throat was poulticed, steam inhalations ordered, and hypodermics of ether given. Tracheotomy was not performed, and the case remained in about the same state for two days, but terminated fatally at night. An autopsy revealed an enlargement of the thyroid body to the size of a turkey's egg. The antero-posterior-diameter of the larynx was shortened and the transverse diameter lengthened by a spreading of the thyroid cartilage. The arytenoepiglottic folds were the seat of an œdema, which, with the depression of the larynx, caused a stenosis of the larynx. Behind the cricoid cartilage, in the œsophagus, was an ulcer 1 ctm. in diameter, with ragged edges and indurated base, which did not communicate with the larynx. The ulceration had uncovered the internal angles of the arytenoid cartilages, and had destroyed the posterior insertion of the posterior crico-arytenoid muscles.—*Jour. des Sci. Méd. de Lille*, Dec. 27, 1889.

The Inoculation of Leprosy.—The "Transactions" of the First Dermatological Congress, held at Prague on June 10 and 12, 1889, contain a paper by Doctor Arning, who inoculated the condemned criminal with leprous tissue at Honolulu. Dr. Arning, in this paper, gives a detailed account of the circumstances connected with the inoculation, of the local manifestations which followed it, and of the subsequent condition of the man as reported to him from the Sandwich Islands. He summarizes the whole case as follows : An apparently healthy, strikingly vigorous man, without any hereditary taint of leprosy, was in the end of September, 1884, inoculated with lepra material, which was taken directly from a child who was the subject of grave tubercular leprosy, and who had passed through an attack of leprous fever. The chief inoculation consisted in the insertion of a small piece of a tubercle in the left forearm. Four weeks afterwards there occurred rheumatic pains, first in the left shoulder, then in the other joints of the left arm, and later a painful swelling of the ulnar and median nerves, all these symptoms occurring without fever, and with very little constitutional disturbance. During the next six months the neuritis gradually abated, and there formed a small leprous nodule in the keloid-looking inoculation scar. In the edges of this keloid scar, sixteen months after the inoculation, lepra bacilli could be found. Then comes a gap in the continuous observation of the patient, on account of Dr. Arning's departure from Honolulu, but it is known that in December, 1887, there were unmistakable symptoms of leprosy in the man. After another year, in September, 1888, the patient was the subject of fully developed leprosy, and, according to the latest reports received, dated March, 1889, there were

evidences that the unfortunate man is already in a condition of marked marasmus, the accounts given pointing to leprosy of the viscera with diminution of the symptoms in the skin. Dr. Arning considers that this history points to a casual connection between the disease and the inoculation which he performed, and he is disposed to consider the peculiar rheumatic affection of the joints of the left arm with the affection of the ulnar and median nerves as the first expression of the differentiation of the disease in the system. Dr. Arning does not consider that the progress of this case shows that there is a four weeks' incubation period in leprosy. He does not think that there is any fixed incubation period, but that, analogous to tuberculosis, the poison finds its way into the system through an unknown portal, without any typical primary disturbance. Sooner or later it is localized in the peripheral system. It often remains, however, for years with very few symptoms, and then, either slowly or with paroxysmal exacerbations, diffuses itself through the entire organism.—*Brit. Med. Jour.*, Jan. 11, 1890.

Renaut on the False Impermeability of Certain Brighty Kidneys and the Therapeutics of Uræmic Coma.—According to the author, it is an œdema of the organ which momentarily overwhelms a slightly diseased kidney. It is necessary, above all things, to promptly relieve local congestion by general bloodletting and the contiguous application of leeches, and to persist until the signs of uremia pass off.

Arterial tension should be raised by the ingestion of water and milk by the mouth, and by half-pint enemata of water every three hours after a primary purgative injection.

In addition to this, almost continuous inhalations of oxygen by means of a large glass inhaler covering mouth and nose.

The author has not tried this treatment in eclampsia or in cases of chronic parenchymatous nephritis.—*L'Union Méd.*, Jan. 23, 1890.

Nunn (T. W.) on a Strange Case of Malingering.—Some years since a delicate looking-girl, aged sixteen, was admitted under my care at the Middlesex Hospital. She had several sores on the right leg. The largest one was situated on the outer aspect of the limb, and was remarkably *quadrangular*. There were besides some patches of skin of variable size which had apparently lost vitality; one of these patches had the same squareness of shape as the largest sore just named, and had, moreover, the same superficies. The dead skin was obviously not slough having origin in any ordinary inflammatory process. On the arms and on the chest, just below the clavicles, were several cicatrices evincing a tendency to cheloid change. The angularity of the main sore and of the large slough, and their resemblance in size and the peculiar drab color of the dead skin, led me to conclude that the condition was produced by the patient herself employing some irritant substance. The color of the dead skin was not like that of a burn by either nitric acid or sulphuric acid, and, besides, a fluid caustic would hardly be got to make a square sore. I directed the Sister of the ward to carefully search the patient's luggage for any article of a suspicious nature. Nothing extraordinary was discovered. However, two square pieces of blue soap were found, and removed as not being included in the list of "patients' necessaries." I took away this soap; after keeping it in a dry place a few days a hard crystalline incrustation of a strong alkali formed on the surface of the soap. As the sizes of the sore and of the cake of soap coincided, there could be no reasonable doubt that we had the clue to the mystery. The patient had a quasi-hectic color in her cheeks, her menstruation was irregular, she suffered much from dyspepsia and thirst. There was some swelling of the right inguinal glands. The mother of the girl informed me that her daughter had been in service, but that she was uncomfortable in her situation, and generally disliked work—in fact, had a vicious disinclination to be industrious. Ten days after her admission she had a rigor, with some subacute phlebitis of the saphena vein; her temperature went up to 104.6°. This pyrexia might have been expected under such circumstances, but during the patient's sojourn in the hospital—namely, from March 30th to July 16th—there were anomalous variations in temperature; with rigors, temperature going to 105.6° on some occasions. My friend, Mr. Geo. Everitt Norton, now of Upper Gloucester Place, was house-surgeon at that date, and most diligently noted the temperatures, and I can quite rely on his accuracy.

It is certainly strange that a child could have discovered that binding a strongly alkaline soap on to the skin would produce sores. She must have done this a long while before she was sixteen, as the cicatrices on the chest were not recent.—*Lancet*, Jan. 4, 1890.

The Cause of Pallor.—Dr. Oppenheimer has published some careful observations on the blood of one hundred and nine pale female subjects (servant girls) conducted by means of Zeiss and Thomas' hæmocytometer and Gowers' hæmoglobinometer. He considers the lowest number of corpuscles per cubic millimetre in a normal state of health as four million, and the lowest amount of hæmoglobin in health ninety per cent. He also agrees with Gärber's dictum: "Number of corpuscles and hæmoglobin both diminished = acute and chronic anæmia. Number of corpuscles diminished, hæmoglobin relatively increased = primary chlorosis or pernicious anæmia. Number normal, hæmoglobin diminished = chlorosis." In severe cases of chlorosis, with tendency to faintness, headache, heart symptoms, and œdema without albuminuria, the hæmoglobin varied from thirty to fifty per cent. In fifty-five of the cases the condition of the blood was normal. These patients were found to be suffering from phthisis, cardiac disease (compensated), gastric ulcer, and various affections of stomach, intestines, or genital organs. Phthisis of itself—that is to say, before hemorrhage or diarrhœa or profuse expectoration had come on—appeared to have no effect on the blood. An interesting result was obtained in connection with gastric ulcer. In simple ulcer the blood was normal, except when there had just been hæmatemesis, but in carcinoma of the stomach both the number of the corpuscles and the hæmoglobin were sub-normal. Pale girls sometimes take iron for a long time without any visible improvement. Dr. Oppenheimer finds that such patients are not anæmic, but chlorotic from some uterine or other affection, so that when the blood is found to be normal it is advisable to make a vaginal examination. The pallor of patients with normal blood appears to be due to the insufficient filling of the cutaneous capillaries. From the observations of Dastre and Morat there would seem to be an antagonism between the blood-vessels of the skin and those of the abdomen; so that if one of these symptoms becomes dilated, the other, by an automatic reflex action, invariably becomes contracted. Because of the fact that irritation of the depressor nerve of the heart induces dilatation of the abdominal vessels and contraction of the cutaneous vessels, Dr. Oppenheimer believes that the pallor of phthisis, cardiac diseases, and kidney mischief is due to reflex action. In these affections the heart has extra work to do, and this affects, by means of the depressor nerve, the vaso-motor centre, causing a diminution of the cutaneous flow, and consequently a dilatation of the abdominal vessels. The pallor observed in most inflammatory affections of the hypogastric viscera may probably be explained also by the reflex action of the hyperæmic abdominal vessels upon the calibre of the cutaneous vessels.—*Lancet*, March 1, 1890.

Stirling (E. C.) on a Case of Hydrocele with Milk-like Contents.—The patient was a boy of nine years who gave the ordinary history of hydrocele of the tunica vaginalis which, on being tapped, gave two ounces of a milk-white fluid. Both on inspection and microscopic examination the fluid presented an appearance very similar to that of ordinary cow's milk. There was no sign of spermatozoa.

Chemical examination revealed the following features: Sp. gr. 1017. Reaction alkaline. Marked reaction of sulphuretted hydrogen with lead acetate. On evaporation, the solid matter was nearly all dissolved by ether, and on evaporation of the ethereal extract there was a yellow residue of fat which saponified readily with potassium hydrate. The solid matter which was not soluble in ether gave the ordinary proteid reactions.—*Australian Med. Gazette*, Nov., 1888.

Page on Post-Mortem Appearances in a Case of Hydrophobia.—Sections of the spinal cord showed the vessels to be very congested, and in places there were capillary hemorrhages. These were most numerous in the posterior segment of the cervical portion. The medulla was much softened, especially in the floor of the fourth ventricle, and there was an excess of leucocytes in that position. The blood-vessels were also very full. No other changes were noted.—*Lancet*, Feb. 8, 1890.

The Bacillus of Mumps.—Cultivations made with the blood of patients suffering from mumps furnish a bacillus, which develops in eight hours. This mi-

robe, which may be termed bacillus parotitidis, is without movement at certain phases of its evolution, but takes the form of an S or V when it divides. When the cultivation medium becomes impoverished this bacillus gives spores. The cultivations assume a murky grayish aspect in broth. When after serving for eight days the broth is filtered, it becomes useless. The bacillus parotitidis dies at a temperature of 60° C. and the spores at 90°. Boric acid and corrosive sublimate mixed in broth in the proportion of 1 to 500,000 checks its development. The saliva furnishes large quantities of these microbes; it is possibly the contagious agent of mumps which would thus result from the deposit of the spores in the parotid duct.—*Brit. Med. Jour.*, March 1, 1890.

DISEASES OF THE NOSE AND THROAT.

BY CHARLES H. KNIGHT, M.D.

Goris on Some Reflex Neuropathies of Nasal Origin.—The author cites eleven cases, of more or less interest, illustrating the relation of nasal polypi, adenoid vegetations, and other conditions, to asthma, migraine, and similar nervous phenomena. He concludes that (1) nasal lesions of different histological nature may produce similar reflex disturbances; (2) the lesion may be situated in various parts of the nasal and naso-pharyngeal cavities; (3) the pathogeny of nasal reflexes is explained solely on the relation between the trigeminal and other centres of innervation (*Rev. mens. de laryngol.*, etc., Jan. 1, 1890).

In *Gaz. méd de Nantes*, Sept. 9, 1890, two cases are reported by Polo, one of hysteria cured by cauterization of the turbinated body, and one of asthma, which was cured by ablation of nasal myxomata. See also *Monatsschr. f. Ohrenheilk.*, 1889, No. 10, a paper by Stein, on the frequency of certain cardiac neuroses, due to nasal affections.

Crossfield (F. S.) on Epilepsy Caused by Intra-Nasal Disease.—Two cases are reported, in one symptoms entirely disappearing, and in the other being much relieved by nasal treatment. In the former case three years and in the latter five months have elapsed since the last seizure. In each case there was nasal stenosis, and consequent mouth-breathing, due to mucous hypertrophies, and in one of the cases to extraordinary enlargement of adenoid tissue in the vault of the pharynx and deviation and thickening of the septum. The usual methods of remedying the conditions were employed.—*Jour. Amer. Med. Ass'n*, Jan. 25, 1890.

Dorn (C.) on Rhinoscopia Posterior: a New Method Recommended for Operations in the Naso-Pharynx.—The patient is placed in what is known to surgeons as Rose's position, the head hanging over the end of a table, and the plane of the face being almost vertical. The examiner, or operator, stands at the patient's head. The velum is held by a self-retaining palate-retractor, and the mirror is passed along the tongue, the mouth being held open by means of a gag and automatic tongue depressor. The rhinoscopic image is said to be brought out with remarkable distinctness, manipulations are found to be extremely easy, and, the head being pendulous, saliva, blood, and pieces of tissue removed cannot fall into the larynx. The method is especially recommended for operations on the naso-pharynx in adults, and for caustic applications in that region.—*Lancet*, Nov. 30, 1889.

Nichols (J. E.) on a Method of Correcting Adhesions between the Soft Palate and Pharyngeal Wall.—A patient was demonstrated showing a remarkably good result. The first step in the operation is to thoroughly cocainize the part. If there is complete closure, the thickness of the adhesion is ascertained by passing a curved steel bougie through the nostril into the naso-pharynx and palpating the end of it by means of the index-finger in the oro-pharynx. When this is done, an incision with a long-handled, sharp-pointed bistoury is made in the median line upon the end of the bougie. The next step is to proceed as if the closure were only partial. An ordinary staphylorrhaphy needle, curved to the right or left, as the case may be, is now armed with four or eight strands of coarse black silk suture. It is then passed through the central opening into the naso-pharynx and carried as far as possible directly outward away from the median line. Then, by a turn of the handle, it is brought into the oro-pharynx. The tissue being very tough, it is necessary to

afford a point of resistance by a long forceps against the palate anteriorly. One end of the suture is then grasped with a long-toothed forceps, the needle is withdrawn, and the suture left in place. The long ends of the strand are then tied with a surgeon's knot near the central opening, leaving the loop loose enough to play freely through both perforations. If the adhesion is bilateral, the same is done on the opposite side. The loop is then drawn around so that the knot lies in the naso-pharynx above the adhesion. The suture is moved slightly from day to day, and at the end of from ten to fourteen days healing takes place, and there remains a small canal of cicatricial tissue slightly larger than the diameter of the suture, through which the latter works freely. Traction is now made on the loop toward the median line, in order to stretch the canal, and into it is introduced very carefully a narrow blunt-pointed staphylorrhaphy knife curved on the flat. The tissue between the two openings is then cut through and the parts are kept dilated by the finger or a retractor until healed. Care must be taken in introducing the knife to make no abrasion in the line of the canal, or the effect of the operation would be nullified. The hemorrhage is slight and controllable and the pain not great. Some nausea and gagging are produced at first by the pressure of the loop, but the pharynx soon becomes tolerant of foreign body, and deglutition is but little interfered with. The chief difficulty met with is in the introduction of the curved needle at the proper angle to bring the point into the pharynyx without engaging part of the faucial pillars. This can be done successfully by holding the handle high against the upper teeth and recollecting the angle of the curve.—*N. Y. Med. Jour.*, Feb. 22, 1890.

Mygind (Holger) on a Case of Acute Hemorrhagic Glossitis.—The writer believes this to be the first case of its kind recorded. The symptoms were those of acute glossitis with the hemorrhagic phenomenon added. The duration of the affection was about sixteen days, the treatment consisting mainly of the use of cold, and the internal administration of ergot. Incisions, as would ordinarily be practised in acute glossitis, were of course not resorted to. No light is thrown upon the etiology of the case, although its hemorrhagic character is attributed to chronic alcoholism.—*The Jour. of Laryngol. and Rhinol.*, No. 1, Jan., 1890.

Lacoarret on a Case of Gummatous Infiltration of the Right Ventricular Band.—After reciting the history of an interesting case, the author remarks that it is not uncommon to observe marked aggravation of symptoms of laryngeal stenosis under the use of iodide of potash. The phenomena are due simply to the irritating effect of the iodide upon the mucous glands and to the resulting hypersecretion, and quickly subside.

Particular attention is drawn to the fact that in old syphilitic cases the iodide alone may be ineffectual, whereas in combination with a mercurial it is promptly beneficial. — *Annales de la Polyclinique de Bordeaux*, July, 1889.

Shalita on Laryngo-Fissure for Laryngeal Tumors.—The author narrates a case of "flat-celled epithelial cancer" removed by thyrotomy, after preliminary tracheotomy *without an anæsthetic*. The operation was repeated a little more than two months later for removal of a growth of indefinite character which had developed in the thyrotomy scar. His conclusions are as follows :

(1) Laryngo-fissure is absolutely indicated in all cases of malignant laryngeal tumors when the latter are circumscribed, and are not accompanied by infiltration of adjacent tissues.

(2) It is indicated further in all cases of suspicious tumors, as well as of benign ones, when the latter are multiple and have broad attachments.

(3) It should be also resorted to in cases of laryngeal tumors in children under ten years of age.

(4) In malignant cases the operation should be performed as early as possible.

(5) The new growth should be always removed together with subjacent tissues.

(6) When the operation is practised with due care (strictly median incision, careful adjustment of sutures, antiseptic precautions, etc.), the patient's voice, as a rule, remains in a satisfactory condition.

(7) When performed under strict antiseptic precautions laryngo-fissure is not dangerous to life.

[The recommendation of laryngo-fissure for benign tumors, even when multiple and sessile, will hardly be generally accepted. The risk to the integrity of the voice should not be underestimated, and more-

over the operation is one of no slight magnitude, especially when preceded by tracheotomy. It is very certain that much can be accomplished by endo-laryngeal surgery with patience and at the hands of an expert. It is difficult to appreciate the writer's insistance upon antiseptic precautions. It is impracticable to entirely exclude the air from wounds in this region and at the same time permit free breathing. Prolonged suspension of respiration must be admitted to be "dangerous to life."]—*Vratch*, 1889, No. 17, p. 389; in the *Jour. of Laryngol. and Rhinol.*, Jan., 1890.

Thost reports a case of laryngo-fissure for papilloma in a man sixty-four years of age. The patient is said to have a "pretty good voice."—*Jour. of Laryngol. and Rhinol.*, Feb., 1890.

Semon on a Case of Bilateral Paralysis of the Abductors of the Vocal Cords.—The patient was a married woman, forty-nine years old, who had been aphonic for eighteen months. As she recovered her voice she developed inspiratory dyspnœa, for which tracheotomy was finally required. The cause of the condition could not be discovered, but the writer suggests that it was a case of complete rheumatic bilateral paralysis of the recurrent laryngeal nerves, and that the adductors had recovered more quickly than the abductors, the latter being during convalescence, thrown into a state of paralytic contracture, in which they remained.—*Jour. of Laryngol. and Rhinol.*, Jan., 1890.

Semon (F.) and Horsley (J.) on the Central Motor Innervation of the Larynx.

1. There is in each cerebral hemisphere an area of bilateral representation of the adductor movements of the vocal cords, situated in the monkey just posterior to the lower end of the precentral sulcus at the base of the third frontal convolution, and in the carnivora in the precrucial and neighboring gyrus. This area has a focus of intensest representation in the anterior half of the foot of the ascending frontal convolution. Stimulation of this point produces complete bilateral adduction of the vocal cords, which lasts as long as the stimulation is continued. Should, however, the latter be unduly prolonged the "*besoin de respirer*" overcomes the influence of the artificial stimulus, and evokes a momentary but powerful abductor movement of the vocal cords. Stimulation of the more peripheral parts of the area evokes less and less perfect adductions as we proceed from the focus outwards, and when the extreme margin of the area is excited only what is known as the "cadaveric position" is assumed by the vocal cords.

The above description applies to the monkey, dog, and rabbit. In the cat we have observed curiously different conditions, for which, at present, we are not prepared to offer any explanation.

2. We have not been able to find an area of representation in the cortex of the abductor movements of the vocal cord.

3. If one of the cortical areas for adduction be so completely excised that stimulation of the neighborhood of the lesion produces no effect upon the larynx, and if the wound be allowed to heal aseptically, no paralysis of the cords is observed. Further, if subsequently the corresponding area in the opposite hemisphere be excited, just as completely bilateral an adduction of the cords is produced, as if the opposite area were intact.

From the above facts we infer that:

(*a*) Unilateral irritation produces bilateral effect. Thus, clinically, in any irritative unilateral affection of this area, spasm of the glottis, that is, bilateral adduction of the vocal cords, may occur, for example, in laryngismus stridulus. That this view is not purely theoretical is shown by the association, in severe cases of the last-named illness, of the glottis spasm with the so-called carpo-pedal contractions. This association is most easily explained on the assumption that we have an overflow of energy from the laryngeal to the neighboring cortical areas for the limbs.

(*b*) Unilateral destruction produces no effect. There is, therefore, no such thing as unilateral paralysis of a vocal cord from lesion of a cerebral hemisphere, as has been asserted. The truth of our statement is made evident by the fact that motor aphasia is not identical with aphonia. Moreover, the observation by one of us [F. S.] of several patients with complete aphasia and right hemiplegia, only a few hours after the apoplectic stroke, has conclusively shown that in such instances the movements of the vocal cords are perfectly preserved.

4. We have observed that, on powerful or long-continued excitation of the laryngeal area, true epilepsy of the vocal cords supervenes, gradually spreading to the neighbor-

ing muscles of the face, neck, head, and upper limbs. From this we conclude that the epileptic cry is not, as has been so long believed, the result of a discharge primarily from the medulla oblongata, but rather represents a stage in the cortical excitement popularly termed an epileptic fit.

5. Whilst we have found so distinctly specialized an area of representation of adduction in the cortex, and no corresponding area of abduction in this region, we have, on the other hand, found that direct excitation of the accessory nucleus of the medulla oblongata evokes abduction of the cords, and never any thing else.

From all the foregoing it follows that our results are in complete harmony with the most recent views of the relation of the cortical to the lower centres; for our experiments have shown that the representation of the laryngeal movements in the cortex is essentially that known as purposive or volitional, since it is adduction, that is, phonation; whilst, on the other hand, the bulbar representation of the larynx is as essentially adapted for the so-called automatic processes of organic life, that is, abduction-inspiration.

Finally, this series of experiments, as well as those we have previously published on the peripheral innervation of the larynx, corroborates in the fullest manner the ideas which one of us [F. S.] has put forward in his first papers on abductor paralysis, namely, the proclivity of the abductors to fail in organic, and of the adductors in functional, disease.—*Brit. Med. Jour.*, Dec. 21, 1889.

Gouguenhem on Prolapse of the Ventricle of Morgagni and Tuberculosis of the Larynx.—Five cases of prolapse are related, three in tubercular patients, the fourth probably tubercular, and the fifth of doubtful character. One case was cured by the galvano-cautery and one by replacement. The right side was the one affected in such case, and the accident seems to have resulted from violent coughing. The author believes that this condition is more common than is generally supposed, but is in doubt as to the precise mode of its production.—*Jour. of Laryngol. and Rhinol.*, Jan., 1890.

Foreign Bodies in the Air-Passages.—Medical literature has recently been crowded with interesting examples of this class of cases, in many of them the foreign body being most extraordinary.

E. F. Grün relates a case of death from impaction of a pea in the left bronchus. The body lodged somewhere without interfering with entrance of air into either lung. At the end of four weeks death suddenly occurred. The left bronchus was found to have been occluded by the swollen pea, which lay at the bifurcation of the trachea, and the left lung was solid and fibrous, the right lung being healthy. The author thinks the pea became dislodged, and produced suffocation, no doubt by preventing, in its new situation, the entrance of air into the right lung.—*Lancet*, Dec. 14, 1889.

Moure relates six cases of foreign body: once spontaneous expulsion occurred, twice death occurred without surgical intervention, and three times the body was extracted. The author justly protests against digital exploration, and urges the importance of using the extracting forceps, under the guidance of the mirror. The use of cocaine, except in the pharynx, is objectionable, since the abolition of the reflexes might permit a foreign body to fall without resistance into the trachea.

Massei, of Naples, relates three cases in which the patients had not perceived the accident, and no symptoms developed until inflammatory reaction was established. In the first case a fish bone was seen with the laryngoscope, at the level of the third tracheal ring. The second case was that of a lady, who was tracheotomized for œdema of the glottis, and who expelled a chicken bone. The third patient was unsuccessfully tracheotomized for infiltration and immobility of the vocal cords. At the autopsy there was found below the cords a large piece of beef bone.

Hovell reports a case in which a piece of bone from a sheep's head, three fourths of an inch long, was removed by means of forceps from the trachea, just below the vocal cords, where it had been retained for two months. In this case the larynx was sprayed with cocaine before extraction was attempted. In a second case, the foreign body was a quarter of a peeled walnut, which was coughed out from the right bronchus at the end of five days.

Linares reports a case of caoutchouc tooth-plate, with two teeth attached, swallowed during sleep. Tracheotomy was done two days later, and removal of the foreign body by the mouth was attempted. It became necessary, however, to open the

larynx and remove it by the wound.—*Jour. of Laryngol. and Rhinol.*, Jan., 1890.

In the *Brit. Med. Jour.*, June 15, 1889, Bryant reported two cases of partial obstruction of a bronchus by a foreign body, in one case a button, and in the other the mouthpiece of a trumpet. In the former case the patient died from exhaustion, and the button was found *post mortem* resting at the first bifurcation of the right bronchus, the whole lung being consolidated. In the second case, the whistle was extracted on the thirteenth day with a pair of forceps passed through a tracheotomy wound. The foreign body lay in the left bronchus, five and a half inches from the lower border of the tracheal wound. These cases are thought to suggest the expediency of performing tracheotomy whenever a foreign body is suspected to be present in the trachea, or beyond either, in consequence of the history of the case, or from the physical signs.

In the *Brit. Med. Jour.*, July 6, 1889, Beverley reports a case in which a threepenny piece was discovered with the laryngoscope, lying across the vocal cords, and producing dyspnœa. It could not be grasped with the laryngeal forceps. Laryngotomy was done, and unsuccessful attempts were made to seize it from below. Thyrotomy was then done, but the coin had disappeared. On the ninth day the coin was passed *per anum*. The patient recovered from the operation, with impaired voice. This observer reports a second case, in which a man coughed up a sixpence which he had carried somewhere in his upper air-passages for ten months, with no inconvenience beyond occasional cough and pain in the throat.

In the *Memphis Med. Monthly*, February, 1890, W. A. Mewborn reports a case of cockle-burr in the right bronchial tube; expectorated after twenty-two months; the patient dying two months later in consequence of the damage to the lung. In the same journal H. W. Tate reports five cases. In two, spontaneous expulsion occurred; in two, life was saved by tracheotomy; and in one death ensued in spite of a tracheotomy, which was apparently done after respiration had entirely ceased.

O. B. Gross reports a fatal case in the *Medical Bulletin*, the foreign body being a marrow-fat pea, which was found in the left bronchus, one and one half inches from the tracheal bifurcation.

In the *Glasgow Med. Journal*, December, 1889, William MacEwen reports a case in which the shell of a hazel-nut was inspired and became embedded in the posterior wall of the trachea. It was exposed and removed by means of a tracheotomy during an attack of extreme dyspnœa.

In the *Peoria Medical Monthly*, Nov., 1889, F. E. Waxham cites an extraordinary case, in the course of an article on foreign bodies in the larynx. The patient was a child fifteen months old. Tracheotomy was done. The foreign body was a vertebra of the fish, with its two projecting spines. As the patient was still unable to breathe comfortably with the tracheotomy wound closed, I concluded to introduce an intubation tube and to close the wound. The assistants held the wound open to facilitate the respiration while the tube was introduced. As this was done, a second vertebra was forced down through the larynx, and expelled through the tracheal opening.

After carefully searching the trachea, and making sure that there were no more vertebræ present, a drainage tube was inserted, the wound closed and dressed antiseptically, leaving the intubation tube *in situ*. The patient rallied well from the operation, nursed without difficulty, and finally made a good recovery. The same writer reports in the *North American Practitioner*, Feb., 1890, a case in which he successfully removed a shawl-pin which had been in the right bronchus for three months.

In the *Cincinnati Lancet-Clinic*, Jan. 4, 1890, J. A. Thompson gives the history of a case in which a piece of oyster-shell was expelled from the larynx by coughing, after having been retained three or four months.

In the *North Carolina Medical Journal*, Dec., 1889, K. G. Battle describes a case in which he removed a "sand-spur," the prickly involucre of a species of grass found along the Atlantic sea-coast, from the larynx of a boy, who had inhaled the object four days before. Several attempts at removal had failed, but it was finally extracted with the Schroetter-Türck forceps under cocaine.

A case of tooth-plate in the laryngopharynx for sixteen days, the subject of a paper read by C. H. Knight at a meeting of the laryngological section of the New York Academy of Medicine, and reported in the *New York Medical Journal*, Nov. 23, 1889, is still under observation. It was

supposed that the damage to the vocal bands was irreparable and that aphonia would be permanent. It has been interesting to see, however, that the gap in the cords has become gradually effaced. On abduction it is quite apparent, but on adduction the cords meet almost perfectly, and the patient speaks with fair volume in a low-pitched, rather hoarse voice, which would be still better but for the presence at the anterior commissure of an excrescence or a neoplasm, the precise character of which has not yet been determined.

REPORT ON OBSTETRICS AND DISEASES OF CHILDREN.

BY ELIZABETH STOW BROWN, M.D.

Bassette (M. Imogene) on Two Cases of Paralysis Occurring during the Puerperal State.—The first case was of a primipara of twenty-two, who seemed to be doing well until three weeks after her labor, which had been entirely normal. She had eaten her breakfast as usual, and an hour after was completely paralyzed, both as to motion and sensation, on the right side. She was also aphasic, but was not unconscious at any time. On the left side, sensation was diminished, particularly in the thorax and arm, but returned to normal on this side in fourteen days. The aphasia was a decided form of the motor variety. She remained under observation and treatment for ten months, during which time she made very great improvement in her paralysis, anæsthesia, and aphasia. For the anæsthesia, faradism with the dry brush was used; and a faradic current, with moistened electrodes, was employed for the motor paralysis. For the aphasia a system of persistent training was undertaken, and met with considerable success. Internally, iodide of potassium and tonics were given.

The second case was of a multipara of thirty-eight, whose puerperium was normal until the eighth day. On that day the nurse was absent, and the patient sat up. When the nurse returned she found the patient standing, reeling, and trying to get into bed, which she managed to do, and then became insensible. On coming out of this condition, several hours later, she was unable to speak or to put out her tongue, but was not otherwise paralyzed. A week later she was taken with a severe chill, but did not lose consciousness. It was then found that she was paralyzed in the right arm and leg. In three or four weeks she was well enough to walk about with some assistance. This second case did not remain under treatment for any length of time. Heart-disease was absent in both cases. In both the involvement of speech, face, arm, and leg, and the presence of contractility to electricity, indicated a cerebral origin for the paralysis. Neither case reported evidences of disease of the kidneys occurring at the puerperal period, and no evidences were present when the patients came under observation. The fact of the occurrence of organic aphasia indicates the probability of the embolic origin of the paralysis.—*Jour. Ment. and Nerv. Dis.*, Feb., 1890.

Lang (Charles L.) on a Case of Unusual Tolerancy of the Pregnant Uterus.—The case was of a woman who had been under treatment for three months previously. Treatment had been begun a few months after her confinement, from which she had not made a satisfactory recovery. The diagnosis had been subinvolution of the uterus with considerable peri-uterine cellulitis. There had been local applications to the cervix and fornices, the hot douche, and, as the physician in charge believed, two very thorough scrapings of the endometrium with Thomas' dull curette. The author, who had been called in consultation, made a vaginal and bimanual examination of the patient. The uterus was as large as it should be at four months' pregnancy. A curette was introduced for the purpose of measuring the depth of the organ, and it passed in easily till the ebony handle blocked up the os. The diagnosis of chronic metritis was reluctantly made, as pregnancy would seem to be excluded both by the treatment and the previous history. However, the case was left largely to nature, and five months later, the patient was delivered of a healthy child.—*N. Y. Med. Rec.*, Dec. 28, 1889.

Obstetric Anomalies. — Dr. W. B. Heryford (*N. Am. Pract.*, Sept., 1889,) describes a form of monstrosity so rare that it is not even mentioned by most obstetrical writers. It belongs to the class of "monstrosities by defect," and has received from Saint-Hilaire the name of *agenesomus*. It is defined as a "malformation in which the

fissure and eventration are chiefly in the lower part of the abdomen ; the urinary or sexual apparatus absent, or very rudimentary." The case described had a face and head perfectly formed, but there was entire absence of abdominal walls from sternum to pubes. The liver was enlarged to about twice its normal size. At the edge of the opening the intestines and spleen were seen lying outside the abdominal cavity. There was entire absence of external sexual organs. On the sacrum there was a tumor of circular form, about six inches in diameter, raised about two inches from the surrounding surface ; on puncture it discharged about half a pint of ropy liquid resembling the liquor amnii. On examination the rudiments of ovaries were found, but no uterus. The child was born alive, but died three hours after delivery. The labor had progressed normally, the vertex presenting.

Dr. J. K. Robertson (*Glasgow Med. Jour.*, Aug., 1889) reports a case of abnormal enlargement of fœtal abdomen, with absent rectum and anus, and enlarged bladder. The enlargement of the abdomen had proved an impediment in labor. After birth, when the anus was found wanting, it was surmised that the abdomen was probably distended by retained meconium. An operation was attempted to find the rectum, but was unsuccessful. By trocar and canula the bowel was reached and there was escape of meconium. The child died on the second day, and on autopsy the cause of the abdominal enlargement was found to be an enormously distended bladder and ureters.

Dr. Larkin (*Brit. Med. Jour.*, Aug. 10, 1889,) describes the case of an infant of four months, from whose back he removed an accessory limb and meningocele. The child was born with a tumor at the back of its neck, which had attained to the size of a small cocoa-nut. This was attached by a broad base to the neck in a line with the upper surface of both shoulder-blades. At its upper part was a dimple of retracted skin, and lower down an extension which felt like a forearm, and terminated in three fingers, which were perfectly formed, even to the nails. On feeling the mass, bones could be diagnosed, which seemed to correspond to an elbow, humerus, and possibly scapula. The family history was interesting in that the aunt had a supernumerary digit on the left forefinger, and an uncle died in infancy after an operation upon a lumbar spina bifida. Operation was decided upon, and on removal the growth was found to be connected with the spinal cord. The child died fifty-six hours after operation. The tumor was found to consist of a meningeal sac with a scapula, humerus, carpal cartilage, and two post-axial fingers, each containing a well-formed metacarpal bone and three normal phalanges.

Burman (C. Clark) on Nocturnal Paroxysms in Whooping-Cough ; An Explanation of Their Frequency.—It is a well-established fact that the paroxysms of whooping-cough are more numerous and severe during the night than during the day ; while closer observation shows that the nocturnal attacks have a special tendency to develop at particular hours. This tendency is not peculiar to whooping-cough, but is noticed in other affections associated with paroxysmal dyspnœal attacks, as asthma, chronic bronchitis with emphysema, and certain cardiac affections.

Mönninghoff and Piesbergen, two of Vierordt's pupils, ascertained by experiment the depth of sleep, using as a sensory stimulus the auditory sensation produced by dropping a lead ball from a given height. For a perfectly healthy man, during the first hour the slumber is very light ; after one hour and a quarter, the depth of sleep increases rapidly, and reaches its maximum point at one hour and forty-five minutes, then falling quickly to about two hours and a quarter ; but later on, after four hours and a half, there is a second small rise, which reaches its maximum at five hours and a half, and gradually falls again until the time of awakening.

The evidence of attendants on whooping-cough patients goes to show that a connection exists between the paroxysms and the depth of sleep. Another factor to be considered in the causation of the paroxysms is the reduction of respiration both in depth and frequency during sleep, and especially that of the first sleep, which is more profound than that of early morning. There is no doubt that the accumulation of bronchial secretion during sleep has an important influence in determining the attacks so frequently noticed when the child first awakens. This is seen in patients with chronic bronchitis who invariably have their morning cough with

copious expectoration ; while the excited condition of the nervous mechanism in a child with whooping-cough under the same stimulus produces the characteristic paroxysm. A similarity is noted between the attacks of asthma and whooping-cough in exhibiting a preference for the night.

In pertussis, there exists an excitable condition of that part of the nervous system included in producing a paroxysm. This nervous mechanism inducing an attack would be more active during the night than during the day ; for the respiratory centre exhibits less resisting power during the night, from the fact of the gradual depression of the breathing occurring during sleep. When the sleep is most profound, it permits the carbonic acid to increase in the blood from less frequent interchange, and at the same time facilitates the engorgement of the lungs, but only to the extent of rousing the respiratory centre to an action more or less excited. Shallow respiration and insufficient oxygenation excite respiratory efforts ; but if no more air gets to the blood, expiration is accentuated and goes on in a convulsive repetition, due to the stimulation of the medulla by the venous blood, but when the centre recovers its excitability, inspiratory effort follows.

Hence in sleep there exists a condition favorable for the action of the causes which induce a paroxysm of whooping-cough ; and in profound sleep, when the respiratory centre is weakened, these causes may be expected to be active.—*Edin. Med. Jour.*, Dec., 1889.

Seibert (A.) on a Reform in Artificial Infant Feeding, with an Improved and Inexpensive Sterilizer and Nursing Bottles.—The author believes that the quantity of a child's food should be regulated by its weight and not by its age. He has prepared a table by which the proper quantity of nourishment for a child can be ascertained according to its weight. The figures presented in this table are the result of careful notes on about two hundred different children. The manner of obtaining the figures was very simple. After weighing the child, the composition and bulk of food was ordered, the latter usually being considerably smaller than before. If regurgitation of food, constipation and dilatation of the stomach and the intestines, with restlessness at night and occasional wind-colic, would not disappear, then the bulk and strength of the food was diminished still more, until the apparent normal boundary line was reached. This was done in all cases. The increase in the food was not ordered until increase in weight had previously indicated it. Whenever the bulk and strength of the milk mixture was increased too rapidly, the infant would invariably indicate this by regurgitating the superfluous amount.

Dr. Seibert has designed a set of bottles and a tray to hold them, which may be placed in any ordinary pot used for cooking in any household. This set of bottles and the arrangements that accompany them are within the reach of the poorest family. They may be obtained at a smaller cost than any other sterilizing apparatus. Eimer and Amend, following the advice of several of the most eminent physicians of New York, are ready to furnish this apparatus all over the land at $1. It includes the tray, eight bottles with stoppers, and two nipples.

The apparatus is not patented and will not be.—*N. Y. Med. Jour.*, Feb. 15, 1890.

Remut on the Treatment of Diphtheria by Means of Acid Sublimate Solution.—The author has in fourteen months treated sixty-two cases with Laplace's solution, and all with favorable results. The solution contains one part sublimate, five tartaric acid to one thousand water (by weight). The object of acid in the solution is to prevent coagulation of albumen, which acts as a barrier to the action of the agent. This solution has therefore special penetrating power. The solution is used to remove thoroughly all the membrane that can be reached.—*Memphis Jour. of Med. Sci.*, Dec., 1889.

Sansom on Mitral Stenosis in Children.—The paper was founded on forty cases clinically observed, and nineteen post-mortem examinations, all in children of twelve years of age and under. As regards morbid anatomy, mitral stenosis in its least pronounced degree was evidenced by a ring of granulations around the mitral aperture on its auricular aspect ; these vegetations might be friable, fibrin-covered, or fibrous and fixed firmly. The subjacent structures were firmer than usual, and formed a thickened ring. In the more pronounced stenosis the mitral curtains were found to form a funnel, the neutricular aperture of which might be of varying

degrees of size to the dimensions of a crow-quill. The surrounding thickening might be extreme to cartilaginous transformation. "Funnel-mitral" was to the "button-hole" in the child in the proportion of eight to one, whilst the button-hole form was the more frequently observed in adults. The left auricle was often greatly hypertrophied or dilated; its wall might be a quarter of an inch in thickness, or it might be dilated outwards and its wall very thin. The left ventricle was usually of normal or sub-normal dimensions; when enlarged it was usually in association with general hypertrophy of the heart and pericarditis. The light chambers were almost invariably dilated. Mitral stenosis was not a congenital malformation. It was extremely rare under the age of five years. It might be considered as invariably the result of endocarditis. In every case examined *post mortem* there was an association with endocarditis, pericarditis, or both these affections combined. In regard to etiology the cases showed a very strong association with rheumatism, though cases were quoted in which mitral stenosis was manifested occasionally without any evidence of rheumatism.

The signs of such cases were either protracted malnutrition, or a sudden lesion of the nervous system. A probable initiating cause was fright, well-defined terror, or slight terror. In such cases a temporary arrest of the heart's action was followed by a violent palpitation, and in the disturbed condition of blood pressure, violence might be done to the delicate valve structures of the child.—*Provincial Med. Jour.*, Feb. 1, 1890.

REPORT ON ORTHOPÆDIC SURGERY.

BY JOHN RIDLON, M.D.

Blanchard (W.) on Mechanical Treatment of Spondylitis.—A chin and occiput head-sling is adjusted, from the whiffletree of which a strong cord is passed through the head-board of the patient's bed, over a grooved wheel to a weight; from a pair of shoe uppers two cords pass, over the foot of the bed to a whiffletree to which a cord and weight are attached. An easily adjusted extension and counter-extension are thus applied in such manner as not to prevent moving in bed. Confinement of the patient to this or any other bed for periods longer than required for rest and sleep will always be more injurious than beneficial. It cannot be too strongly condemned. A gallows is built over the patient's favorite chair by means of wood uprights rising two feet above the patient's head with a connecting cross-bar at the top. From the whiffletree of a head-sling two cords run over grooved wheels at the centre of the cross-bar and down each of the uprights to a level with the patient's waist, where window sash weights are attached. A stiff leather belt is placed around the body just below the armpits, to which are attached two leather or wooden rings six or eight inches in diameter, through which the arms pass, and straps connect the rings with the whiffletree above the head. The body and shoulders are thus made to divide part of their own weight with the head sling.

The patient's dining-chair is fitted in the same manner. A perambulating gallows should be built on the same plan, with sash weights running up and down the uprights in tubular boxes, and the whole supported on casters; or a Case wagon may be used with sash weights substituted for the spring, which is a most objectionable affair, inasmuch as it is either lax or tense, according to the position of the patient, on the same principle as a pair of spring-scales, and which largely defeats the intention otherwise evident in its construction. All these weights should be increased within the range of easy tolerance.

The patient is further fitted with a shell-back leather splint, made to fit when he has been forced (by prolonged stretching) into the best possible position, and to which is attached a frame for supporting the head by means of an occipital pad reaching from ear to ear and a frontal band.—*Med. Standard*, Feb., 1890.

Post (S. E.) on Basilar Kyphosis: Its Relation to Certain Cerebral Deformities.—1. The essential feature of basilar kyphosis is sharpening of the occipito-sphenoidal angle. It is associated with a steeply inclined basilar process and superficiality of the anterior cerebral fossæ—characteristic fœtal conditions.

2. The direct effect of basilar kyphosis is to shorten the base and to diminish all of the diameters of the skull.

3. Basilar kyphosis is not necessarily associated with premature synostosis of the base of the skull.

4. Basilar kyphosis has been found in cases of congenital cerebral hernia. In this connection it is supposed to exclude the intra-cranial pressure as the cause of the cranial defect.

5. Basilar kyphosis has been associated with the symmetric cortical atrophy of infantile biplegia. It is supposed to cause this condition by bringing the corpus callosum into collision with the falx cerebri and inducing inhibition or atrophy proceeding centrifugally to the cortex upon both sides.

The mother's deprivation of food during her pregnancy, together with the delayed ossification, may not inappropriately suggest intra-uterine rachitis as a cause of this deformity. In the case of biplegia to which reference has been made, the ordinary signs of rachitis were very evident. Rachitis as a basis for biplegia may not impossibly repay investigation.—*Medical Record*, Dec. 21, 1889.

Bauer (W.) on Lateral Curvature of the Spine; Resection of False Ribs an Indispensable Palliative.—The patient is advanced in life and has suffered from the mechanical effects of an aggravated scoliosis for many a year. Of late a new trouble has developed. The two false ribs of the right side come with their ends in painful contact with the right ilium; the iliac muscle and the structures in general occupy the left iliac fossa.

The contact is so frequent and painful as to seriously interfere with the ordinary motions of the body. Though we have not the slightest hope of reducing the existing spinal deformity, we are certainly able to relieve the patient of the last most irksome symptoms by operatively shortening the offending ribs to such an extent as to effectually prevent their collision with the ilium. The result was quite satisfactory.—*St. Louis Clinique*, Jan., 1890.

Croft (J.) on the Present Stage of Surgical Treatment of Tubercular Disease of Joints.—The facts on which the operationist party base their policy are something like these: that when tubercular disease commences in joint structures it follows the same course that it does in other structures of the body; that it may cease to develop, and then may undergo spontaneous cure; that it may develop and undergo caseous degeneration, and the caseous products may liquefy and give rise to abscess; that the local condition may be followed by infection of other parts of the body; that the tubercular element is artificially inoculable, and is auto-inoculable, and this latter kind of infection may suddenly take place upon a long period of local quiescence. The line of action which has been taken on this basis of facts has been in the direction of what has been called early excision, and the latest development of this prompt action has been thus formulated by Mr. A. Barker: "That in cases where general tubercular disease does not contra-indicate it, the infected tissue of a joint should be thoroughly removed so soon as it is suspected that caseation is advancing in it." When other treatment has failed to arrest the disease of the joint, and there are signs that caseation has commenced and is advancing, then the operation of excision should be performed. The operation should go wide of the disease and proceed with as little violence as possible, and with the object of obtaining primary union or union by first intention.

The writer then goes on to discuss *seriatim* the objections that are maintained against excision, under the following heads: mortality, necrosis, shortening, duration of illness, risk and precipitation of general infection, incomplete ablation of disease, transitory character of tubercular tendency.

The statistics of Mr. Howard Marsh, as given in his lectures at the Royal College of Surgeons, are taken as the standard of the anti-exsectionists. These are compared with the results of Mr. Wright and the writer's own recent cases.

Since 1879 he has operated on fifty-six cases. This total shows a mortality of 12.6 per cent.; of these deaths, 7 in number, 2 only were attributable to the operation.

This second group shows: cures, 33; under treatment, 12; untraced, 4; deaths, 7; total, 56. Mortality reckoned at 12.6 per cent.; when untraced cases allowed for, at 13.6 per cent.—*Lancet*, Feb. 8, 1890.

Ridlon (J.) on Some Practical Points in the Treatment of Hip Disease.—Plaster-of-Paris is usually a convenient, and, if applied from the ankle to the axilla, a comfortable form of dressing. The objections to it are: The splint must be renewed about every month; the bandages for each splint will cost from $2 to $3; it is not easy to apply a plaster

splint from the ankle to the axilla, the patient being supine; it is difficult to obtain the best possible position for the thigh; the parts cannot be inspected without the removal of the splint; the splint becomes loosened after a few days, so that some movement is possible; it is easily soiled by the excretions of the patient, and is hardly practicable when there is a discharging sinus.

Treatment by traction with a Buck's extension and weight and pulley, however useful as a temporary expedient, is not satisfactory as a plan of treatment. It does not prevent flexion and adduction resulting from involuntary muscular spasm, and it does not prohibit voluntary motion at the joint. The method employed by Howard Marsh, at the Alexandria Hospital, in London, is far more satisfactory, and may be employed whenever the circumstances are such that traction in bed is desired. The method is as follows: Traction is made, always in the line of deformity, by adhesive plasters and weight and pulley applied in the usual way; the arms are passed through webbing loops, that are joined by a strap across the chest, and these are snugly fastened to the bed, thus prohibiting any attempt at assuming the sitting posture; and a long, straight board splint is applied on the well side from the axilla to below the foot, to prevent voluntary lateral movements, and make it possible to control any abduction or adduction that may be present. The chief objection to this method is that it confines the patient absolutely to bed, whereas it is often desirable to get patients out-of-doors as early as possible, and always necessary to give the joint some protection during locomotion for many months after the acute inflammatory symptoms have subsided.

To one who is satisfied to treat tubercular joint disease in any part of its course without traction, or who is so circumstanced as the general practitioner is, that he must treat all walking cases without traction, and to one who believes that immobilization, and not traction, is chiefly indicated in the management of these cases, Thomas' splint will prove of great service. Any man who can drill a hole and drive a rivet can make a Thomas splint; and the only instrument maker any one needs is the blacksmith and the shoemaker. The cost of the splint thus constructed should not exceed $2.50. —*N. E. Med. Monthly*, Jan., 1890.

Thomas (H. O.) on the Treatment of Injuries of the Neck of the Femur.—In my practice a hip splint is employed for the treatment of fracture of the femur's neck; also fractures of this bone just below the trochanter. The splint is identically similar to that used for ordinary cases of hip-joint disease. If it has to be applied to elderly patients, then between the appliance and the trunk is placed an imitation of a small mattress, formed of about six or eight folds of soft linen or bed sheeting. When it is decided to apply the hip splint to fractures just below the trochanter, then the buttock bend is nearly obliterated, so that the machine is almost a straight line from the top to the bottom wing. The essentials of the treatment are:

1. To uninterruptedly and as effectually as possible arrest flexion of the hip-joint.

2. To continue the treatment until the symptoms of genuine repair and soundness of the joint are diagnosed. As with patella fractures, so with these, the younger the patient the longer the period of restraint.

3. To obtain the best possible restoration circumstances permit, so that no lameness attributable to flexion be a permanent remainder of treatment.

As regards the first, the appliance for arresting flexion of the hip-joint should extend from the axilla to a point on the lower extremity; which point should be the same distance from the hip-joint as the axilla is from the joint, so that the hip-joint corresponds to the centre of the appliance. A greater length of limb- than trunk-portion is a mere incumbrance, and a shorter trunk- than limb-portion is valuable aid lost for stopping flexion. This is so obvious that attention needs only to be drawn to it.

An equally balanced appliance of full measure enables the patient to be comfortably moved about the bed, and the necessary acts of nature performed with very little distress.

Concerning the second. To make sure of a useful result to our treatment, the patient should feel free from all discomfort on removal of restraint, and respond satisfactorily to the *flexion test*.

As regards the diagnosis and prognosis of injury to the neck of the femur, here will only be discussed types which the surgeon has generally brought under his observation. The symptoms attendant upon each are nearly always complicated by the

concurrent signs of injury to the hip-joint; the latter sometimes appear early, but usually later on and gradually overshadow the symptoms of the former. If the patient has merely strained the whole joint, the sign of this, felt by the patient, but not obvious to the surgeon, except by the flexion test, makes any injury to the whole joint apparent early; but where fracture exists it intensely affects the patient and occupies the surgeon's attention, early overshadowing the articular injury; it is only when the irritation attendant upon the fracture has much subsided that the milder but more persistent symptoms of joint injury are noticed, and their meaning interpreted correctly or perhaps incorrectly. The error of interpretation is often made after the lapse of some weeks or months, that of supposing there primarily must have been a fracture, which chronic injury to the joint much simulates, giving rise to difference of opinion among the surgeons who may be consulted; those first consulted, maintaining that there was no fracture to be detected, but those consulted some months later greatly suspecting a fracture, from the deformity present, and account for the delay of cure. To specially diagnose whether the fracture be impacted or not, extra- or intra-capsular, is no aid to treatment, no matter which of them the surgeon may have to treat; if the condition of the patient before referred to permits, the whole details of treatment ought to be employed. If a fracture exists which the surgeon fails to detect, he ought to be on the alert for signs of mere injury to the joint. Although fractures of the neck of the femur frequently happen during infancy, as well as the declining period of life, if detected early, a very rare occurrence during early life, their treatment presents no difficulty.—*Provincial Med. Jour.*, Jan. 1, 1890.

Grant (H. H.) on Resection of the Hip-Joint for Tuberculous Coxitis.—The writer takes the ground that all cases of hip disease which do not progress favorably should be subjected to operative interference with view to remove all diseased tissues. After reviewing the literature on the subject, and reporting two cases, he deduces the following conclusions:

1. All hip cases not directly traumatic are tubercular.

2. It is wise surgery to proceed to operative measures with a view to resection in all cases of hip-joint disease not showing favorable progress under faithful mechanical trial.

3. The functional results are in every way comparable after resection with those of the expectant plan.

4. It is not proved that under careful antisepis there is added danger of general infection, but rather the contrary.—*Am. Pract. and News*, Feb. 1, 1890.

Ridlon (J.) on Fixation and Traction in the Treatment of Hip Disease.—The question was considered from the position of *Fixation* as opposed to the traction hip splint when used as an ambutatory apparatus. It was held that the traction hip splint when so used not only failed to prevent motion antero-posteriorly, laterally, and in rotation, but that it tended to increase vertical motion even beyond that obtainable in a healthy joint. It was held that an inquiry into the results of any plan of treatment should, at the least, consider the mortality; the duration of treatment; the general health during treatment; and, bearing directly upon this, the length of time patients are confined to bed; the frequency of abscesses which go on to operative interference or spontaneous opening; the ultimate condition of the limb as to its usefulness; the amount of actual shortening—*i. e.*, shortening due to erosion, displacement, and arrest of growth; the amount of apparent shortening, *i. e.*, the actual shortening plus the shortening dependent upon flexion and adduction; and, finally, the degree of motion at the joint.

The statistics of Gibney, Cazin, H. O. Thomas, Robert Jones, Judson, C. F. Taylor, and Shaffer and Lovett are considered, and the following conclusions are drawn: That it does not appear that sufficient evidence has been presented to demonstrate that the results of the use of the traction hip-splint are any better than, or as good as, those obtained by any purely fixative apparatus; nor does it appear that the results are any better than those where the "expectant treatment" or no treatment has been employed; nor has it been shown that the use of the traction splint shortens the disease. On the other hand, the statistics quoted have shown that it does *not* prevent actual shortening from arrested growth, from erosion of bone, and from subluxation; that it does *not* prevent apparent shortening from flexion and adduc-

tion ; and that it does *not* prevent stiffness at the joint. It has also been shown to *cause* in-knee and super-extension at the knee by stretching the ligaments, and weakness and talipes equinus at the ankle.

The most often repeated, if not the only, charges made by the tractionists against pure fixation (without traction) is that it does not so quickly relieve the pain—a point yet not proved, and that it favors actual shortening from erosion of bone. The statement that pure fixation removes apparent shortening by preventing flexion and adduction they do not object to. And the statement that fixation does not induce ankylosis in a tubercular joint is no longer questioned.—*N. Y. Med. Jour.*, Feb. 15, 1890.

Thomson (W.) on the Operative Treatment of Tubercular Disease of the Knee-Joint.—After discussing the relative merits of erasion and excision, the writer concludes as follows :

I believe that once we determine upon cutting open a knee-joint in general tuberculosis of the synovial membrane, we had better go the whole way, and perform the ordinary excision. The operation is, I maintain, safer and more satisfactory in its general results than erasion. My own hospital experience, and as far as it extends to the practice of my colleagues, is a mortality of one in over fifty successive cases. That leaves little to be desired ; and I am satisfied that the patients who have been submitted to excision of the joint have, on the whole, been better treated than if they had undergone exploratory incisions and tentative scrapings at the hands of a surgeon.—*Provincial Med. Jour.*, Jan. 1, 1890.

Sharp (J.) on a Simple Plan of Treatment for Bow-Legs and Knock-Knees.—In bow-legs, after the child has been prepared for bed, and any bathing, rubbing, and manipulation made a part of the treatment gone through with, the child is placed on its back, the feet brought accurately together with a pad of absorbent cotton to relieve pressure on the malleoli ; a strip of adhesive is passed under the heels so that ends are about of equal length on each side and long enough to reach around over instep across the other foot, passing entirely around the feet, thus securely fastening them together ; then the knees are brought together, with a pad of cotton between the condyles, if necessary, and secured by adhesive twice around. In one case of knock-knee under treatment, a pad of antiseptic wool, covered, and with broad tapes attached, is nightly placed between the condyles ; while the feet are secured together by a pair of shoes fastened together at the heels, the toes pointing outward at about 30° from a line perpendicular to the median line of the body.—*Kansas City Med. Rec.*, Dec., 1889.

Davis (G. G.) on the Treatment of Bow-Legs.—It is advised to treat the condition causing the bow-legs ; to remove the child from his feet ; to bandage the leg to a splint on the inner side of the leg in fairly marked cases ; and it is emphatically urged not to apply braces and let the child walk around. In well-marked cases presenting themselves after the sixth year, operative measures are advised.—*Univ. Med. Mag.*, March, 1890.

Scudder (C. L.) on a Report of Eighteen Cases of Chronic Disease of the Ankle and Tarsus, with Observations upon the Operative Treatment.—After a careful and extended consideration of the literature on the subject, and of the cases in question, the following conclusions were drawn :

Excision is safe.

The mortality is not great.

The convalescence and time of after-treatment are short.

The disease in the foot is ended.

The prognosis is sure.

Profuse suppuration and its consequences are avoided.

The likelihood of septic infection is at a minimum.

The partial operation of curetting is of very little value.

There is no mutilation of the foot.

The usefulness of the ankle and foot is very great after excision.

The question of tubercular infection from operative interference is yet unsettled ; but there is a strong presumption that partial operations of curetting favor infection.—*Boston Med. and Surg. Jour.*, Jan. 30, 1890.

Ellis (T. S.). Notes on the Nature and Treatment of Flat-Foot. — (1) The foot is supported not only *in* but also *by* the exercise of its functions. The muscles, which by action move, in action sustain the structure. In early life they also develop the form.

(2) Ligaments are insufficient to resist tension when continuous or prolonged.

On the other hand, intermittent tension promotes their strength.

(3) Muscles, developed by action, tend to remain taut and firm when not in action, and so, by keeping up continuous pressure, modify the bony contours.

(4) As failure of muscular support tends to deformity from yielding of ligaments, so a renewal of it, in specially active degree, will renew the form.

(5) In good walking the heel is raised from the ground by the calf muscles and by the long flexors, acting, with the peronei and tibialis posticus, at the same time.

(6) While the long flexor muscles press the toes against the ground, they tend to lift up the heads of the metatarsal bones (forming the anterior pillar of the arch), which thus dance, so to speak, on tight ropes. Injurious pressure against the ground is thus prevented, when the weight is borne by the anterior pillar only.

(7) This same action relieves all strain on the ligaments beneath the tarsus while drawing the two pillars towards each other and throwing the arch upwards, just as tightening a bow-string increases the bending of the bow.

(8) In flat-foot the indication is to promote this bow-string or tie-rod action by vigorously springing to tip-toe, both as a special exercise and in walking. Avoidance of continuous strain on the ligaments, as in careless standing, is also indicated.

(9) While frequent rising to tip-toe during any necessary standing is desirable, prolonged standing, even in the tip-toe position, is not desirable. In this latter case the muscles are wearied by continuous contraction, and the ligaments lose the benefit of intermittent tension. It is the act, the movement of rising to tip-toe that is beneficial.

(10) As in order to have free movement upwards the heel must first completely descend to the ground, heels to the boots should be avoided.

(11) The mechanism of the foot is best adapted for a level surface. The sole of the foot, therefore, must not be thickened on the inner side, as sometimes advised.

(12) As the free bending of the foot necessary for efficient function takes place only, or mainly, at the oblique line of the metatarsophalangeal joints, a thick sole is altogether inadmissible.

(13) The short flexor muscles, acting with the abductors and adductors, play an important part in holding down the proximal phalanx of the first and the middle phalanx of each of the smaller toes, while the long flexors act on the terminal phalanges.

(14) The principal object of the arch being, as I contend, to protect these sole muscles from pressure, steel springs, cork, or other pads which press against them are to be scrupulously avoided.

(15) The great toe having its natural plane of movement obliquely downwards and inwards (away from the others), it is important that all interference with this lateral movement should be avoided, otherwise the action of its flexors may be suspended.

(16) In such case the bow-string or tie-rod effect of the action of the long flexor on the tarsal arch is lost. In this regard I attach nearly as much importance to proper socks as to proper boots.

(17) As the arch is most pronounced and best adapted to sustain weight, and as the muscles for raising the heel and pressing down the toes act best, when the toes are directed slightly inwards, the toes should never be turned outwards in standing or in walking.

(18) Free movement of the feet being impossible when the body rests on their outer edges, standing or walking in that position is not to be permitted.

(19) As muscles when tired tend to as little action as possible, and so to throw extra strain upon the ligaments, all fatigue is to be avoided.

(20) Inspiration, straightening of the spine and khee, throwing of the arms upwards, and of the head backwards, are all of them movements instinctively associated with the act of rising to extreme tip-toe. All these tend to throw the body, as a whole, into good position. Therefore, any exercise or form of work which involves springing upwards with every inspiration, coming downwards with every expiration (such as wood-cutting), should be encouraged. All exercise or work which involves continuous effort (such as holding up weights) is to be avoided, especially if it involve the squatting position.—*Edin. Med. Jour.*, Jan., 1890.

McClintock (J. C.) on Congenital Talipes Equino-Varus.—The author urges that the treatment be commenced at birth and carried to completion by the time that the child begins to walk. The

general practitioner is the one to undertake the treatment of these cases, and he should understand the methods of the expert and acquire the necessary technique, especially as he is the one who first sees the case at a time when the simpler methods of treatment are of so much more avail than at a later period, and because the simplest and cheapest appliances give the best results.—*Kansas Med. Jour.*, Dec., 1889.

Earl (G. H.) a New Club-Foot Apparatus.—The apparatus consists essentially of a bent spring, applied to the foot by means of bandages, or to the boot by means of straps, in such a way as to make traction in two directions upon the deformed foot. Six wood-cuts illustrate the apparatus, its application and the results of its use.—*Med. Record*, Dec. 14, 1889.

REPORT ON DISEASES OF WOMEN.

BY JOHN S. HAWLEY, M.D.

Byford (Henry) on a Case in which Three Peritoneal Sections were Made within Nine Months.—The patient suffered from retroversion of the uterus and enlargement of the right ovary, which, after local treatment, etc., had failed to relieve, was removed by vaginal section. The left ovary, being in an apparently healthy condition, was not disturbed. The uterine displacement becoming troublesome and much pain in the left ovarian region having developed, the abdomen was opened for the purpose of removing the remaining ovary. This was found to be in a healthy condition and was not disturbed, but the uterus was fixed to the adbominal wall by suturing the stump of the broad ligament on the right side and the ligament itself on the left side to the anterior adbominal wall. Within three months she returned, the pain in the left side having increased in severity, and with great tenderness of the ovary, which was found just behind the posterior wall of the inguinal canal, it having been drawn forward by the suturing of the broad ligament to the abdominal wall. The uterus was well sustained by the adhesions produced by the last operation. The ovary was removed by opening the inguinal canal, incising its posterior wall, and ligating the pedicle in three portions, making a broad flat stump, avoiding any traction on the portion sustaining the uterus by adhesion to the abdominal wall. The author can find no record of any inguinal oöphorectomy in which the posterior wall of the canal was opened, all others having been performed for the removal of ovaries lying within or at the opening of the canal. The patient was entirely relieved of her symptoms.

The author does not believe that the left ovary would have become diseased if the broad ligament had not been sutured to the abdominal wall at the second operation, although recognizing the advisability of removing both ovaries and tubes, even when one only is diseased, in the greater number of cases. He therefore concludes that in cases in which retroversion exists and oöphorectomy is performed, the uterus should be fixed anteriorly by suturing the pedicle only to the abdominal wall in unilateral operations, or by suturing the fundus itself, or by Alexander's operation. The broad ligament should not be sutured unless the ovary and tubes have been removed. — *N. Am. Practitioner*, Jan., 1890.

Kelly (H. A.) on Hysterorrhaphy, and an Improvement in its Technique.—The outline of the author's paper is as follows: The natural supports which retain the uterus in normal position are, for convenience of study, considered as acting at three points: (1) Pelvic diaphragm below, (2) utero-sacral ligaments behind, (3) broad ligaments in front.

(1) Pelvic diaphragm catches the blows of succussion and intra-abdominal pressure; is in no way weakened by the clefts of rectum, vagina, and urethra, as these are either placed excentrically, or cleave it in an oblique direction.

Weakening of the pelvic diaphragm throws the weight of the uterus on (2) and (3), which finally yield, resulting in a displacement of the uterus.

Repair of this injury by closure of the enlarged vaginal outlet.

(2) Relaxation of the utero-sacral ligaments involves a displacement of the cervix downward in the vagina, and a consequent backward displacement of the fundus uteri.

Repair of this injury not to be attained by operation; substituted by packing, pessary, etc.

(3) Relaxation of the broad ligaments

results in backward displacement of the fundus uteri—retroposition or retroflexion.

Repaired often by simple packing or pessary in vagina, keeping cervix well back in the pelvis.

Sometimes all attempts per vaginam and rectum fail. In these cases hysterorrhaphy will succeed.

Conclusions.

All the uterine supports must be examined in every case of displacement.

Where several factors conjoin to produce displacement, (1) and (2) must in all cases be repaired first, then, if further infra-pubic treatment fails to remedy the remaining defect in (3), supra-pubic hysterorrhaphy is called for.

Hysterorrhaphy — defect of previous method is that the attachment of the uterus to the abdominal wall by its anterior face feathered it backward, thus putting it at a mechanical disadvantage.

New method here described is the attachment by the ovarian ligaments, thus throwing the uterus into marked anteflexion.

Three cases had been treated by this method, which allows of the sinking down into the pelvis of the uterine body from stretching of adhesions, but not of posterior displacement of the *fundus uteri*. Through a short abdominal incision (1½ in.) the fingers are passed down behind the uterus, separating any adhesions which bind it to the pelvic floor or walls, and as the fundus is brought forward the ovarian ligament is brought into view by drawing the ovary and tube of one side through the incision. A carrier is then passed beneath the ovarian ligament, and three sutures, which have been passed through the parietal peritoneum as soon as the cavity had been opened, are conducted by it around the ovarian ligament. These are not tied until the same procedure has been followed on the other side, the sutures, three on each side, thus attaching the ovarian ligaments at a point midway between the uterus and the ovary to the parietal peritoneum at the site of the abdominal incision. The sutures are then firmly tied after replacing the ovaries and tubes and ascertaining, by passing a finger into the incision, that no intestinal or omental tissues are caught in their loops, the ends are cut close to the knots and the abdominal incision closed. By this method the uterus is thrown into a position of marked anteflexion, the intra-abdominal pressure tending to increase this in degree, so that the subsequent reproduction of the original misplacement is prevented. In all cases the ordinary plastic operations of colpo- and perinæ-orrhaphy must precede the abdominal section, which is only to be employed in cases which cannot be relieved by packing, pessaries, etc.—*Johns Hopkins Hosp. Bull.*, Jan., 1890.

Madden (Thos. More) on the Treatment of Congenital Atresia of the Vagina.—It may not be superfluous to observe that the operative procedure necessary in attempting the formation of an artificial vagina in cases of congenital atresia of this passage is not such as may be safely undertaken without great caution and some special experience by any surgeon. He cites the following record from the practice of an old chirurgeon, whose boldness was apparently ill warranted by his particular skill in this instance. De Haen narrates the following case, which serves as a lesson and a warning.

"A lady, twenty-four years of age, after having tried for eight years such remedies as seemed best calculated for exciting the menstrual discharge, became affected with a large hard swelling of the abdomen. At length it was discovered that imperforation of the vagina was the sole cause of all the bad symptoms which the patient had long endured. An incision was made which enabled the operator to introduce his finger into a large cavity, giving vent to a considerable quantity of blood. It was thought that an opening had been made into the vagina; but, the patient having died three days afterwards, it was seen that a mistake had been made, as the cavity in which the finger had been introduced was that of the bladder. The vagina was closed below by a substance one inch in diameter and half an inch thick. The upper part of this passage, the uterus, and the Fallopian tubes were exceedingly enlarged, and filled with a dark-brown sanious fluid. A similar fluid was extravasated in the abdomen through a rupture which had taken place in the Fallopian tube. The ovaries were in the natural state."

It should, moreover, be observed that in several instances in which no operation was attempted death had resulted from rupture of the distended Fallopian tubes, or of the uterus itself, and consequent extra-peritoneal extravasation, leading to fatal peritonitis or septicæmia.—*Lancet*, Feb. 8, 1890.

Routh (A.) on Urethral Diverticula.—The histories of three cases and references to others form the basis on which the author discusses this condition.

The literature on the subject, though dating from 1847, is scanty and scattered. The symptoms are progressive discomfort and frequency of micturition, dyspareunia, and the formation of a swelling which appears at the vaginal orifice. Pressure upon the swelling causes thin, offensive, irritating pus to pass into and out of the urethra. Cases are recorded showing that if these diverticula are left untreated, retrograde changes occur along the urinary track. The physical signs are unequivocal, differing on the one hand from dislocation of the urethra, and on the other from simple dilatation of the middle third of the inferior wall (urethrocele). The diverticulum is essentially a urinary pouch or cyst communicating with a urethra of normal calibre, usually in its middle third, by an orifice relatively narrow. The etiology seems to be: 1. Closure of the ducts of pre-existing urethral glands, retention cysts resulting. Suppuration and ulceration into the urethra by a small, often valvular, hole follow, and the inflammation is kept up by urine trickling into the sac at each act of micturition. 2. Blood cysts which have passed through similar changes. 3. The formation of pseudo-cysts by injury to the urethral floor during labor or instrumentation. Pregnancy, with its increased local activity, seems usually to induce the formation of these cysts, and parturition appears to be often the immediate cause of the rupture. The treatment is mainly surgical. 1. Where urethritis or cystitis exists, the cyst wall should be dissected out, and cut off close to the urethra, and the vaginal wound left open for drainage. 2. Where the urinary passages are healthy the cyst should be dissected out, the opening into the urethra enlarged to allow drainage, and the vaginal wound at once closed. In either case the urine should be drawn off till union is assured.—*Lancet*, Feb. 13, 1890.

The Abuse of Uterine Treatment.—We have from time to time directed attention to the insignificance of certain conditions of the uterus which have been supposed to hold an important place in the pathology of that organ, and have combated pathological theories which are not only wrong, but which also involve methods of treatment that are often dangerous to life and generally injurious to the health both of body and mind of the patients concerned. It has been a misfortune to women that from the time—now fifty years ago—when attention became directed to the diseases peculiar to the sex, their study has proceeded along very narrow lines, and pathological theories have been formulated upon insufficient and often erroneous data, and made the basis of universal treatment. At one time inflammation of the cervix was the theory generally accepted, and its treatment consisted in the application of caustics to the os uteri once or twice a week for months. After a time stricture of the cervical canal shared the field with inflammation, and this was supposed to be cured by the introduction of bougies at weekly intervals for an indefinite period. Subsequently flexions were discovered, and displacements were soon magnified into an efficient cause of all the ills of women, and upon them was built the superstructure called "the mechanical system of uterine pathology." Their treatment by pessaries of all kinds, shapes, and substances followed as a matter of necessity, and the pessary required such careful looking after that in many cases it demanded a daily visit. After this the great discovery of conical cervix and pinhole os was made, and chronic inflammation and stricture of the canal rapidly retired from the field. This discovery demanded a cutting operation, and the wearing of a stem for weeks or months. The method proved dangerous, occasionally even fatal; it has, however, been practised to a large extent, and is still occasionally adopted. Yet later, laceration of the cervix was discovered to be the great cause of suffering in women, and "the greatest surgical triumph of this century" was invented for its cure. This surgical triumph consists in paring the lacerated surfaces and stitching them together. Then massage came to the front. It is true that this mode of treatment is not specially directed to the cure of uterine diseases, but rather to the cure of cases which a few years ago would have been regarded as uterine and would have been treated on one of the plans enumerated above. These are some of the theories which have been held with regard to the diseases of women and the methods employed for their cure. Against these views and methods of treatment the voice of the more thoughtful practitioners in this country has often been

raised, but in America "minor gynæcology" of the worst type has always been encouraged, and its practitioners have been regarded as the advanced guard of the department, so that we find ourselves pleasantly startled and surprised on reading a paper by a leading American physician, Dr. Goodell, of Philadelphia, on the "Abuse of Uterine Treatment through Mistaken Diagnosis," published in the *Medical News*. We heartily congratulate Dr. Goodell on his emancipation from views, some of which have been proved by laborious researches to be wrong, while others are, on the surface, of such an improbable character that they should be received only on the production of irrefutable proof of their correctness.

It has hitherto been the custom among certain gynæcologists to accept any theory of uterine disease put forward unless it is disproved. No custom has been more disastrous to the scientific progress of this department of medicine, and it should be reversed; no theory, by whomsoever advanced, should be tolerated unless proof of it be forthcoming. Had this rule been observed, uterine pathology would not have been in its present chaotic state, and Dr. Goodell would not have to complain of the abuse of treatment through mistaken diagnosis. Dr. Goodell concludes his paper with the following watchwords as broad helps to diagnosis.

In the first place, "always bear in mind, what another has pithily said, 'that woman has some organs outside of the pelvis.' Each neurotic case will have usually a tale of fret or grief, of cark and care, of wear and tear. Scant or delayed or suppressed menstruation is far more frequently the result of nerve exhaustion than of uterine disease. Anteflexion *per se* is not a pathological condition. It is so when associated with painful menstruation, and only then does it require treatment. An irritable bladder is more often a nerve symptom than a uterine one. In a large number of cases of supposed or actual uterine disease which display marked gastric disturbance, if the tongue be clean, the essential disease will be found to be neurotic; and it must be treated so. Almost every supposed uterine case characterized by excess of sensibility and by scantiness of will-power is essentially a neurosis. In the vast majority of cases in which the woman takes to her bed and stays there indefinitely from some supposed uterine lesion, she is bedridden from her brain, and not from her womb. I will go further, and assert this to be the rule, even though the womb itself be displaced, or it is disordered by a disease or by a lesion that is not in itself exacting or dangerous to life. Groin aches and sore ovaries are far more commonly symptoms of nerve exhaustion than of disease of the appendages. Uterine symptoms are not always present in cases of uterine disease. Nor when present and even urgent do they necessarily come from uterine disease, for they may be merely nerve counterfeits of uterine disease."

In the main these conclusions are sound and healthy, but the author shows some hankering after his old views, especially with regard to anteflexion, and a little too much affection for his new love—nerve exhaustion,—a syren which has proved as dangerous as any uterine fad. In spite of these blemishes, we cannot help feeling that the outspokenness of Dr. Goodell will prove an enormous benefit to the study of the diseases of women in America. Already even the effects of this outspokenness are observable. In a discussion on painful menstruation which took place recently in the Obstetrical Society of Philadelphia, only a small number of the speakers proved themselves to hold orthodox views upon "minor gynæcology." The majority expressed views which were strongly antagonistic to the meddlesome local treatment which has been in favor for so long a time. This is highly satisfactory. We shall accordingly look forward with pleasure to sound scientific and pathological work from the obstetricians of America, instead of the "inventions" in pessaries, instruments, and minor operations for conditions of which so little is known.—*Lancet* (Editorial), Feb. 22, 1890.

[We quote this lengthy but highly humorous arraignment of the American gynæcologist as "she is saw" by the aid of a prismatic monocle, which exaggerates the writer's myopic astigmatism when he unchains and then "sics" a stony but visually defective British stare, made even more than usually suggestive of a glance from the stiffening eye of a self-petrifying gorgon by the influence of the lens on the distorted image he describes. His ocular defect prevents him from seeing the record of American "minor gynæcology," which stretches in the horizontal meridian far

back into the past—the instruction it gave to the "more thoughtful practitioners" of Great Britain in the treatment of vesico-vaginal fistula; of the true character of the fictitious "inflammatory ulcer" of the cervix, and how to cure it without converting the surrounding tissues into a mass of cicatricial tissue; of how to repair a ruptured perineum without agglutinating the buttocks and causing the partial sloughing of the tissues in the ischio-rectal fossæ from the barbarous quilled suture; of the treatment of chronic cystitis by cystotomy; of the proper shape and adaptation of the lever pessary and the use of the prolonged hot-water douche—are these lessons to be ignored because certain enthusiasts regarded some method of treatment as of wider scope than the reality, or the cause of progressive changes in the accepted pathology of an infant industry of medical science? True, our English friends have never exhibited an undignified haste in leaving the old rut and primitive plow with which they and their ancestors had made feeble scratches in the hard ground, and using the steam plow offered them by the American minor gynæcologists who were cutting deep, even furrows in the virgin soil. No, it took from three to fifteen years before they had learned their pieces, and then delivered them so quietly and gradually that the uninformed stranger never dreamed that the performance was a dress-rehearsal, and not a souvenir celebration of the five hundredth night of the run.

Although none can gainsay the fact that uterine pathology has been rather volatile and metamorphic in character, it seems somewhat in excess of the needed amount of a good thing when the quip regarding the rejection of any theory of uterine disease which is not absolutely proven as the only anchor to cast to windward possessed by the storm-tossed gynæcologist if he would fain rescue his frail bark from the cruel waves of the angry sea of conflicting opinions as they strive to dash it a shattered wreck upon the fangled and bloodthirsty rocks of "minor gynæcology." And it becomes rather mouldy and preempted by a colony of worms who have no sense of humor through having lived on an exclusive diet of senile *persiflage* that had long since outlived its usefulness and had become so saturated with the ptomaines from the dead—Oh, so dead! bodies of long-forgotten witticisms that danger to all was imminent as long as it should be left at large—does this pleasantry, when aspiring spirits are practically given full permission to drape the limbs of a whole grove of hickory-trees with their raiment, but are ruthlessly interdicted from all aquatic exercise until they shall have proved themselves to be expert swimmers? But the master-jest, the right royal jest, the imperial monarch of all jests, is shown in the peroration of this right merry discourser. It is a pretty wit that can adduce from the bare fact that local treatment is often unnecessarily administered because of *errors in diagnosis*, and from the further fact that uterine pathology is still in an undifferentiated state, that—mark the delicate flavor and masterly action of this quip—the American gynæcologist should remain at home, beat his speculum into a paper-cutter, and desist from his nefarious actions with things he but slightly understands. And then, when the pessary and the cotton tampon, the applicator and the probe, the scissors and the tenaculum shall have passed away, and no man shall wot whither they be departed, then shall there perchance come to the ex-meddlesome local treater and esquire of dames out of the dim, far-reaching whence, a proven uterine pathology and a wondrous knowledge of the mathematical point at which the retroverted uterus no longer sways the destiny of the female backache, and at which the rule of the prankish and frolic Empress Neurasthenia de Neurosis begins. But where do our starving children come in?

J. S. H.

REPORT ON NERVOUS AND MENTAL DISEASES.

BY FREDERICK PETERSON, M.D.

On Methods of Mechanical Treatment of Locomotor Ataxia.—Since Charcot took up the suspension treatment of tabes according to the method of Motchutkowsky, every neurologist in Christendom[1] has experimented with it and

[1] To this statement the editor of THE ANALECTIC must take exception, as it places him either beyond the pale of Christendom, or outside the turbulent field of neurology. If the writer by "every neurologist in Christendom" means *every neurologist outside of New York*, the editor is content, as he can stand relegation into *heathendom* better than banishment from his chosen specialty. But to be deprived of the title of neurologist because the knee

contributed to current literature his favorable or unfavorable views as to its value. As is often the case with remedies advised in incurable diseases, it has had transitory beneficial effects in some patients, it has been followed by no result whatever in others, and in a few it has been productive of evil, and even of fatal, consequences. A large array of devices for the purpose of stretching the spine has been placed upon the market, from a modification of the mediæval inquisitorial rack by a Vienna physician to the comparatively simple gibbet of Sayre. In many office-corners the latter now stands idly by, a mute monument to many buried therapeutical hopes, or a three-legged mendicant acting as an office-servitor.

The practice of suspension for a minute or two or three, several times a week, does not seem to have accomplished every thing that it promised, but as a passing fashion it has emphasized the fact that considerable good may result in many cases of disease of the spinal cord from the mere mechanical manipulation of the flexible canal containing it. It has furthermore led a number of medical troglodytes to ferret out from the dark caverns of literature old and similar methods, lost to sight until now or forgotten.

Branting, almost half a century ago, was accustomed to treat tabes by massage along the back while the patient was hanging by his hands to a horizontal bar, and in later works upon this subject, such as Hartelius' "Sjukgymnastik," various flexing and twisting movements are recommended to be combined with massage in the treatment of this disorder. Some of the European mechanico-gymnastic institutions have long employed different species of friction and vibration for the same purpose.

Professor von Jürgensen has just called attention to a system of mechanical treatment begun by the German orthopædist, Hessing, more than fifteen years ago (*Medicinisch-chirurgisches Centralblatt*, Jan. 3, 1890). Instead of stretching the spine for a few minutes at long intervals according to the Russian method of suspension, Hessing has supported and extended it day and night, year after year, by means of an accurately-fitted corset with flexible and extensible steel supports between the fixed points of the shoulder and pelvis on each side. It is maintained that extension of the spine may be induced in this way, but there is good ground for the statement of some orthopædists that apparatus of this kind can never be made to assume more than a quarter of the weight of the body borne by the spinal column. The shoulders are not fixed points, but, on the contrary, very movable and uncertain.

Hessing's method has been productive of improvement in case of locomotor ataxia to about the same degree as when they have been treated by other mechanical means. There is probably some one underlying principle in all these systems, but exactly what change is brought about in the morbid process in the spinal cord by their employment it is far from easy to determine. Release of compressed nervous elements by the stretching of sclerotic tissues, improvement of the circulation in the blood-vessels and lymph channels, and various other hypothetical influences have been adduced to explain the somewhat obscure phenomenon.

As some cases of tabes are susceptible of amelioration by any of the methods described, and as in all of them the fundamental object seems to be to attain a certain degree of extension of the spine, perhaps it would be best to abandon the more complicated methods and apparatus and rely upon simple exercises capable of fulfilling the same purpose, such as hanging from a horizontal bar, bending over to touch the toes with the fingers while the legs are straight, and rotatory movements of

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will not bow to, nor the tongue confess, Motchutkowsky, is too much. From the earliest publication THE ANALECTIC has taken a firm stand against *the suspension treatment of locomotor ataxia*, and the editor has only allowed its literature to occupy space in its pages to warn readers against this *unscientific*, *quackish*, and *dangerous* therapeutic procedure. He begs the reader to refer to page 101 of the present issue, where Cagney has experimentally proven that suspension does not lengthen, but *shortens*, the spinal column, thus pricking almost the last bladder of this foreign echinococcus which our aping ways have so long allowed to prey upon our scientific vitals.

The details of broken necks, strangled throats, dislocated spines, inhibited heats, ruptured vessels, and worse still, quackishly depleted pocket-books of patients, would already fill a book.

The editor is proud to say that, while his claims to the title neurologist are small, they have never been detracted from by suspending or allowing to be suspended one single patient of his, suffering from locomotor ataxia or any other incurable disease. With the Bergeon foul-air treatment per anum, and the Weigert hot-air treatment per orem, the suspension-treatment will die the death all medical fakes deserve. R. W. A.

the spinal column.—Editorial, *N. Y. Med. Jour.*, March 8, 1890.

On the Treatment of the Acute Insane in General Hospitals.—Last year a revised code of lunacy laws, under the name of the Gallup Lunacy Bill, passed the New York Legislature, and only failed to become a law by the opposition of the Governor. The same bill is to be introduced again at the present session. The New York Neurological Society, at its January meeting, appointed a committee, consisting of Dr. Frederick Peterson, Dr. Charles L. Dana, and Dr. Ralph L. Parsons, to examine and report upon this proposed new law. After commenting favorably upon some very excellent features of the bill, and after vigorously opposing the method of commitment prescribed therein, this committee closed its report at the February meeting with a number of recommendations, among which one in particular is deserving of careful attention, because of the novelty of the suggestion. We refer to the following: "A clause should be introduced into the bill providing that nothing in the lunacy laws of this State shall be construed to interfere with the reception and treatment of acute cases of insanity in chartered general hospitals, in the same manner and under the same conditions as patients suffering from other diseases are there received and treated, provided such hospitals have suitable accommodations approved by the State Commission in Lunacy."

In our opinion, this is the most valuable portion of the committee's report, for it suggests a step forward in the line of a great reform. The day of huge aggregations of persons with chronic and acute insanity in the palatial caravansaries known as asylums, where the mere attendance to the physical wants of the patients is often deemed sufficient therapeusis, is about to pass away. The insane are no longer to be considered in the light of dangerous criminals, and asylums are not always to bear the stigma of existing as a species of jail. What is the fate of a person with acute, curable insanity—one that could recover in from three weeks to three months—when sent to one of these "cathedral" institutions? His personality is entirely lost in the horde of from six hundred to two thousand mad people among whom he is placed. The superintendent, usually busy with the farming and plumbing, seldom has time to see the patients. A young assistant physician, commonly of small experience, takes the patient in hand along with the two hundred that he is to see twice daily. He can not spend more than three hours if he will with the two hundred patients, because the clerical work required of him consumes not only most of his day, but part of his night. The patient is considered, not as an individual, sick and requiring treatment, but in relation to the other patients of the ward. Does he disturb others? Then narcotize him. If that is impossible, put him into the pandemonium known as the "back ward." There his sick brain, before haunted only by his own phantasmagoria, beholds materialized the hideous spectres of his imagination. And it is doubtful if any one in delirium has ever seen aught to compare with the waking nightmare of a "back ward" in some asylums.

Doubtless most asylum authorities do all in their power to improve the environment of their charges as far as is possible under present conditions, but proper individualization must necessarily be unattainable in such a concourse of people and with such small assistance. Hence it is that of late the question of radical reform in the present methods of caring for the insane has become more and more prominent. They are hereafter to be treated, at least in the earliest stages of their aberration, like other sick persons, only with greater delicacy and care, because the most complex and sensitive organ of their bodies is the one that is diseased.

We read of the provision of reception houses in New South Wales and Queensland, and of lunacy wards in public hospitals in Victoria, for the treatment of insanity in its early stages. A psychopathic hospital with a hundred beds is about to be built in London, the administration of which is not to differ from that of a general hospital. The staff is to consist of a resident medical officer of asylum experience, and assistant, four visiting physicians, a consulting surgeon, an ophthalmologist, an aurist, a laryngologist, a gynæcologist, and a pathologist. A still later step in the direction of reform is the organization of an out-patient department at the West Riding Asylum, near Wakefield, England, which is calculated to change the present routine line of action completely with regard to the early treatment of the insane poor.

With these facts in mind, we cannot speak too favorably of the action of the committee of the New York Neurological Society. Their proposition to place it in the power of the sixty-three chartered general hospitals of this State to open special wards for the reception of the acutely insane, under the same conditions precisely as other classes of patients are received, would lead to vast improvement in the early and efficient treatment of the nutritive disorders of the brain. It would create a number of reception wards in various parts of the city and State, where there is now absolutely no place for such purpose. Bloomingdale is overcrowded and about to be removed from the city. The method will lead to greater individualization, a deeper scientific study of insanity, and the training of nurses and practitioners for the better recognition and care of insane patients in their own homes, and many will recover without having attached to their name and reputation the inevitable stigma of having been in an asplum.—Editorial, *N. Y. Med. Jour.*, Feb. 22, 1890.

Mettler (L. H.) on the Dietary for the Nervous System.—The nervous tissue requires for its constitution the chemical constituents of the albumenoids and fats together with phosphorus. Hence the chief alimentary substance is the albumenoids (provisional formula C_{72}, H_{112}, O_{22}, N_{18}, S) contained in milk, eggs, cereals, the juices of vegetables, and the muscular substance of meat. Water should be freely indulged in by neurotic types of constitution, almost *ad libitum*. Among the meats most suitable are, in their order, beef, mutton, lamb, and pork, and the brains of animals. Fish is not so valuable as reputed, but may be employed to vary the diet. Oysters, on the other hand, are extremely useful as nerve reconstructives. Among vegetables, wheat stands at the head of the list, containing, as it does, fatty matters and phosphoric acid. Rice, corn, oatmeal, barley, and sweet potatoes are better than onions, carrots, beets, turnips, etc. Fruits are useful as adjuvants because of the sugars they contain.—*The Dietetic Gazette*, Jan., 1890.

Clouston (T. S.) on Dipsomania.—The author, in some recent articles on diseased cravings and paralyzed control, speaks as follows of dipsomania: We can get no scientific idea of dipsomania so long as we do not distinguish it from true alcoholic insanity. The greatest difficulty in the diagnosis of dipsomania is undoubtedly to distinguish it from drunkenness, where the control is not paralyzed, but simply not exercised. Especially is it difficult to tell where the stage of sane, responsible, punishable drunkenness ends and that of dipsomania begins, in those cases where the latter arises out of the former. The chief clinical facts that prove the presence of such a disease, or tend to prove it, are:

Marked remission and periodicity.

The diseased craving and paralyzed control having followed, as effect follows cause, brain injury, loss of blood, mental strains, bodily disease, conditions of anæmia or exhaustion, critical periods of life, or an attack of mental disease.

A change in the whole mental, moral, and emotional character, coincident with or closely related to the drink craving.

A mental or neurotic heredity.

A marked neurotic diathesis.

A congenital weakness in the inhibitory qualities of the brain, brought out by emerging into life or having new opportunities of indulgence.

That the patient had normal control at one time, and exercised it under temptation to yield when he chose, but that the excessive use of alcohol has destroyed the brain's power of control, and has set up a morbid craving, this being usually evidenced in other ways than mere drinking.

The author then proceeds to the classification of dipsomaniacs upon an etiological basis as follows:

1. Development and retrogressive dipsomania.
2. The dypsomania of a neurotic diathesis.
3. Somatic dipsomania.
4. The dipsomania of excess.

1. Under the developmental and retrogressive form he would include the congenital cases whose higher inhibition had never been developed as a brain faculty; the cases arising at puberty and during adolescence, a numerous and an unfavorable class; those occurring at the climacteric, a not uncommon kind in both sexes, but especially in women; and the senile class, also not rare.

The general features of the congenital class of dipsomaniacs are a slight weakness of mind, inhibitorily in all directions, impulsiveness, lack of moral sense, want of

balance, keen unreasoning likes and dislikes, want of power of application, want of common-sense, and distorted and often remarkable social instincts.

The next is the adolescent form of dipsomania, which is common enough. More true dipsomaniacs develop the habit of excessive drinking and acquire a keen craving for it, between the ages of 18 and 25, than at any other age. It seems to be one of the developmental neuroses, standing in the same class as the cases of adolescent chorea, hysteria, insanity, epilepsy, and Friedrich's disease. Like those diseases, it seems to indicate a failure in the perfecting process of the organism. There is always a neurotic heredity in such cases; but there is not, in the author's experience, any psychological or physical type that would lead one to predict this likelihood of dipsomania in any young person, except that he should expect him to have the characters of the neurotic diathesis; but he would have this in common with a great many who would not become dipsomaniacs at all, nor develop other neuroses.

The dipsomania of the retrogressive periods of life, which are usually accentuated at the climacteric and senility, is not so common as at adolescence, but is far from being rare. Few practitioners but have met with cases of women who had led sober, self-controlled lives up to the menopause, and then took to alcohol to counteract the feeling of weakness and lack of energy and of enjoyment that they experienced. The commencing failures, mental and bodily, of senility, too, are sometimes attempted to be fought off by liquor, with the result that the liquor becomes master of the situation, and useful and respected lives are terminated in disgrace and dishonor.

2. The next kind of dipsomania is that of the neurotic diathesis. There are unquestionably some persons of high brain qualities, especially of keen sensibilities and poetic minds, of practical force and of conscientiousness in a high and even hyperæsthetic degree, but yet who have small staying power, are soon tired, are apt to be carried away by the very force and intensity of their emotions, and who are very sensitive to their own sensations of weariness.

He has known several cases of neurasthenia take to stimulants as an antidote to their bad feelings, and very soon lose control over the cravings thus set up.

In the neurotic dipsomaniacs it is the morbid intensity of the pleasure felt from drink that cannot be resisted. Their very strong point of keen sensibility is the rock that shipwrecks them. With their brain protoplasm alcohol has an especial affinity. They take to opium, to cocaine, to gambling, and to exciting employment to excess, all for the same reason, their oversensitiveness. They are mostly thin, and have not too good digestion. When they become teetotalers they are rabid antidrinkers, with no charity at all to those who can drink in moderation. One does not despair of the cure of a neurotic drunkard if abstinence can be enforced in time. Many such people have very strong volitional and inhibitory powers. They are not the facile fools not worth trying to save.

3. By "somatic dipsomania" he would distinguish those cases where traumatism, sunstroke, paralysis, brain erysipelas, brain lesions of all sorts, so weaken the self-control, that men who had previously led sober lives then acquire marked cravings for liquors and cannot control those cravings. The author has seen examples of every one of these lesions inducing dipsomania as one of their symptoms,—indeed, had known several cases where falls and blows on the head and sunstroke induced it as the only mental symptom.

Under this category, also, come these cases where the craving appears after losses of blood, after severe illnesses, during conditions of anæmia and chlorosis in women after childbirth, during lactation, and during pregnancy. Usually there is not only a craving for drink, but not much tolerance of it. A small quantity excites and intoxicates or stupefies in such cases. A small amount will sometimes cause violent delirium, and the traumatic and sunstroke cases show homicidal and suicidal impulses soon passing into actual delusional or impulsive insanity. All those are very hopeless varieties except the anæmic, chlorotic, and nerve-exhausted varieties. Nourish and fatten such cases, and they will often get well.

4. The "dipsomania of excess" is the most difficult form of any to deal with theoretically or practically. By it is meant that form where there is no special heredity, no neurotic diathesis, no disease, and no critical period of life, and where there has previously been a prolonged excessive use

of stimulants. A bad habit has been voluntarily cultivated, and has grown in strength until it has become master. There was no natural lack of self-control, but most probably a natural love of liquor and its effects. It is only after many years that the habit has grown into a disease, and there is no special time at which the one ended and the other could be said to have begun, nor any perceptible line of demarcation between normal liking and diseased craving, nor between possible control and paralyzed inhibition.—*Edinburgh Med. Jour.*, Feb., 1890.

Insanity in Australian Aborigines.—In a paper read before the Intercolonial Medical Congress of Australasia, Dr. Morton Manning, the Inspector-General of the Insane in New South Wales, gave a most interesting account of the cases of insanity found to have occurred among the aborigines of Australia. Mental disease would appear to have been a very rare affection whilst they were in their primitive and uncivilized condition, and the manner in which they dealt with the few cases which did arise was of the most drastic nature. "If the lunatic was violent or aggressive he was promptly slaughtered; if melancholy he was allowed, if so disposed, to commit suicide; if demented and helpless he was allowed to die; and only when quiet and peaceable, and when his erroneous ideas did not result in offensive acts, was he allowed to continue in the tribe." In the course of time, as the aborigines were brought more into contact with civilization and its attendant vices, insanity increased rapidly in proportion to the number of the population, and Dr. Manning states that since 1868, 18 aborigines had been admitted into the asylums of New South Wales, from a population which has never during that time exceeded 2,500, and is now less than half that number. In the census year, 1881, the proportion of the aboriginal insane to the aboriginal population of New South Wales was 2.83 per 1,000, a proportion in excess of that for the general population, and at the close of 1887 it was upwards of 5 per 1,000. The causes of insanity in the 32 cases of aborigines admitted into the asylums of Queensland and New South Wales were in a considerable proportion of the cases due to drink. The prevailing type of the malady was mania passing rapidly into dementia, with filthy and degrading habits. All the melancholic cases originated in jail. Three were epileptics. No case of general paralysis or any thing like it was seen. There were 20 deaths, and in several cases the only cause which could be assigned was marasmus—a gradual wasting without tubercular or other manifest ailment. The average duration of life was much shorter than in Europeans; the confinement, though tempered by many unaccustomed comforts, being apparently the great factor in shortening life.—Editorial, *Brit. Med. Jour.*, Feb. 15, 1890.

Stammering.—In the *Provincial Med. Jour.* of Feb. 1, 1890, is an anonymous letter from a physician, himself a victim to this unpleasant habit, and which contains so many points of practical interest that portions of it are here reproduced:

"Having lately received several circulars from different professors who advertise their secret methods for the cure of stammering, I have thought that a personal experience might be of interest and value. I shall not attempt a learned physiological analysis of the nerve-centres and nerves involved in the different muscles, and sets of muscles, in stammering, but rather aim at a simple statement.

"Since twenty years of age I have been, though not wholly, yet fairly free from the trouble. In my earliest remembrance of speech, and all through my boyhood, I was a terrible stammerer. I have only heard of two epileptics in my family: one a woman, a first cousin, the other a boy, a second cousin, both on the father's side.

"The occasions on which I have stammered for thirty years past, and yet stammer, are about as follows: From habit acquired in travel, and in India, and to save the legs of the maid, I prefer to go out of my room, and call to the maid for what I may want. For two years I had a favorite maid called Mary. It was in vain for me to attempt to call out 'Mary'; my lips would compress, the upper teeth seizing the flesh inside the under-lip; the word would not come without extreme and painful effort; but there was one way towards perfect relief, I always called, 'O Mary'—*i. e.*, I placed a vowel breathing before the consonant, and thus unlocked the complex, and in a harmonious coördination of brain, nerve, and muscle involved in the production of 'M.' In reading a lecture before a public audience, a terrible word is 'Method'; within the last ten years my upper teeth have

made wounds inside the under-lip in getting out this word. I naturally avoided the ridicule of inserting a vowel-sound before an audience. Another occasion on which I am still constantly bothered, is in saying 'good-morning,' as I am shown out of a front door by master or maid; something unduly glues my tongue over the 'g' in 'good.' I get over this difficulty by bringing into operation another mental act, and the action of a different set of muscles, by the act of lifting my hat; I can say 'good-morning,' without stammering, whilst in the very act of lifting my hat. Here the same principle is involved as in putting a vowel before 'M,' spasm of certain muscles is relieved by diverting nerve-energy to other channels and other muscles. Again, if I feel that I am about to stammer in any word, I try to substitute another word. Often, in public reading, if I avoid the difficult word by some substitution, the same difficult word may recur many times, and I can speak it with little or no difficulty.

"If I am reading a lecture in public which is legibly written, and if I have previously read it aloud to myself, I shall stammer little or not at all—in other words, I do not stammer when the nervous system is calm. Similarly, if speaking in a public discussion, I confine my mind to one simple point at a time, I do not stammer, but if the mind, in its active tumultuousness, sees too much or too widely the other possible relatives of the subject, and a fear of a want of clearness comes over the mind, then my speech is full of stammering.

"The points which have seemed to me important toward avoiding stammering, are to seek nervous calmness; if this be not attainable by the will, the sufferer can do something to divert the præ or present spasms—such as drawing in the breath, always keeping the lungs well filled with air in speaking, walking up and down the room, moving other parts of the body by an act of will, taking up a book or ornament, etc. I have made it a strict rule never to seek to force myself to say the difficult words, but stop, and use another word; or substitute some other words immediately preceding the difficult one. The sufferer should read aloud when alone, both poetry and prose. Stammerers rarely stammer in reading poetry aloud, when alone; the mind and nerves, by poetry, are induced into harmonic rhythm, just as they are by dance music, and irregular action is prevented. The words which the stammerer finds most difficult when in society, he will find easy enough, especially in poetry, when reading aloud in his chamber. I do not think that he should practise on these words, except when alone, and in the most calm way; he needs rather to read naturally as it comes, to forget that he stammers, and by practice of natural reading and speaking aloud when alone, to educate the just coördination of the nerves, etc. I found it best to walk to and fro in my chamber whilst reading aloud."

Drunkenness and Responsibility.—Chief-Justice Coke long ago formulated the legal dictum that the inebriate criminal was doubly guilty, the inebriety aggravating the offence. But the justice of this dictum has of late years been challenged. Baron Pollock has held that the plea of irresponsibility was tenable in a case where a homicide was committed by a person after taking a small quantity of alcoholic liquor—a quantity not sufficient ordinarily to disturb the reasoning faculties, but which, in the case in question, was sufficient to set in motion an insane predisposition that became the prime agent in the manslaughter. Another eminent judge in England has recently ruled, in regard to the case of a drunken mother, who, through the neglect of her babe, occasioned its death by starvation, the withholding of nourishment by the mother was not a crime for the reason that it was undesigned, and that it is not a declared crime to imbibe too much liquor.

Chief Baron Palles has ruled that neither law nor common-sense can hold a man responsible for the acts done under the influence of an intoxicant, if, by reason of long vigil, deprivation of sleep, or impoverishment of the blood, he shall have become so reduced as to be made drunken with a smaller quantity of liquor than would have produced that effect upon him in good health. Justice Day has gone still further, and has declared that a person who does not know the nature and quality of the acts he commits, is not responsible for them, whatever may be the cause of his unconsciousness.

The thought contained in these decisions is a complete reversal of the ground of decisions that have been respected for three hundred years by the general public, that have been on a thousand grave occasions accepted by the criminals themselves

without a whisper of dissent, and that have passed almost unquestioned by jurists until within the present decade.

The Congress of Psychology, held at Paris last August, was unanimous in proposing that the government should be called upon to more thoroughly protect society against criminal dipsomaniacs, and to erect special asylums for the treatment of habitual drunkenness.—*Jour. Am. Med. Assoc.* (extracts from editorial), Feb. 1, 1890.

Schirmer (H.) on Loss of Knee-Jerk in Acute Mania.—In the *Münch Med. Woch.*, 1889, Nos. 17 and 18, the author describes four cases of acute mania, in the convalescent period, in which there was a gradual disappearance of the patellar reflexes, with gradual return of the same upon their entire recovery. Three of these he observed in the psychiatric clinic at Freiburg, while the fourth had been noted by Prof. Emminghaus in the Dorpat asylum. The author considers this remarkable phenomenon due, in all probability, to some functional disturbance in the posterior columns of the cord.—*Centralb. für klin. Med.*, Oct. 26, 1889.

Gombault and Mallet on a Case of Tabes in Childhood.—The patient was admitted to the hospital at the age of ten years. The disease began at seven years. Hereditary neurotic taint. There was general weakness of the extremities; a flaccid paresis of the lower limbs; incomplete paresis of the upper; loss of tendon reflexes; anæsthesia of muscular sensibility; ataxia of the arms; some atrophy of muscles in the hands; marked tactile anæsthesia, analgesia, and thermanæsthesia in all the extremities; no tremor, and no cerebral disturbance. Death took place at the age of fifty-eight years. The autopsy showed sclerosis of the posterior columns, and some atrophy of the gray substance of the cord.—*Arch. de méd. expér. et d'anat. path.*, 1889, No. 3.

Miura (M.) on the Pathology of Kakke.—This author, who has contributed much to the literature of the group of diseases generally known under the name of beri-beri by his articles on kakke, has arrived at the following conclusions regarding the latter disease:

The kakke poison is contained in spoiled fish (*Pelamys orientalis*, *Thynus albacora*, and others of the family *Sombridæ*).

There is no marked fatty degeneration of the muscles in acute or in chronic kakke, although, in the chronic form, the author has found diminution in calibre of the muscular fibres.

In severe chronic cases there is marked accentuation and reduplication of the second sound of the heart, disappearing with the recovery of the diaphragm from the paresis characteristic of the disease. A spontaneous arterial tone, due to energetic and sudden tension of the elastica during arterial diastole, is of prognostic importance because its appearance and disappearance are closely related to the retrogression and improvement in the disease.

Faradization of the phrenic nerves is an important agent, indicated in every case where diaphragmatic paresis is marked.—*Centralb. für klin. Med.*, No. 16, 1889.

Nostrums Sold as Particularly Useful in the Treatment of Intemperance.—At the last meeting of the American Association for the Study and Cure of Inebriety, held in November, 1889, the Committee on Nostrums reported the percentage of alcohol in so-called cures, or aids to cure, as follows:

	Per cent. of alcohol
Dr. Buckland's Scotch Oats Essence..... (Also ¼ gr. morphine to the ounce.) A more insidious and dangerous fraud can scarcely be imagined, especially when administered as this is recommended, for the cure of inebriety or the opium habit.	35.
The "Best" Tonic.....	7.65
Carter's Physical Extract.....	22.
Hooker's Wigwam Tonic.....	20.7
Hoofland's German Tonic.....	29.3
Hop Tonic.....	7.
Howe's Arabian Tonic. "Not a rum drink"	13.2
Jackson's Golden Seal Tonic.....	19.6
Liebig Co.'s Coca Beef Tonic.....	23.2
Mensman's Peptonized Beef Tonic.....	16.5
Parker's Tonic..... "A purely vegetable extract. Stimulus to the body without intoxicating. Inebriates struggling to reform will find its tonic and sustaining influence on the nervous system a great help to their efforts."	41.6
Schenck's Seaweed Tonic..... "Distilled from seaweed after the same manner as Jamaica spirits is from sugar-cane. It is therefore entirely harmless, and free from the injurious properties of corn and rye whiskey."	19.5
Atwood's Quinine Tonic Bitters.....	29.2
L. F. Atwood's Jaundice Bitters.....	22.3
Moses Atwood's Jaundice Bitters.....	17.1
H. Baxter', Mandrake Bitters.....	16.5
Boker's Stomach Bitters.....	42.6
Brown's Iron Bitters..... "Perfectly harmless. Not a substitute for whiskey."	19.7

Burdock Blood Bitters	25.2
Carter's Scotch Bitters	17.6
Colton's Bitters	27.1
Copp's White Mountain Bitters	6.
"Not an alcoholic beverage."	
Drake's Plantation Bitters	33.2
Flint's Quaker Bitters	21.4
Goodhue's Bitters	16.1
Hartshorn's Bitters	22.2
Hoofland's German Bitters	25.6
"Entirely vegetable and free from alcoholic stimulant."	
Hop Bitters	12.
Hostetter's Stomach Bitters	44.3
Kaufmann's Sulphur Bitters	20.5
"Contains no alcohol." (In fact, it contains no sulphur, but 20.5 per cent. alcohol.)	
Kingsley's Iron Tonic	14.9
Langley's Bitters	18.1
Liverpool's Mexican Tonic Bitters	22.4
Oxygenated Bitters	Acid.
Pierce's Indian Restorative Bitters	6.1
Z. Porter's Stomach Bitters	27.9
Rush's Bitters	35.
Dr. Richardson's Concentrated Sherry Wine Bitters	47.5
"Three times daily or when there is sensation of weakness or uneasiness at the stomach."	
Secor's Cinchona Bitters	13.1
Shony's German Bitters	21.5
Job Sweet's Strengthening Bitters	29.
Thurston's Old Continental Bitters	11.4
Walker's Vinegar Bitters	6.1
"Free from all alcoholic stimulants. Contains no spirit."	
Warner's Safe Tonic Bitters	35.7
Warren's Bilious Bitters	21.5
Wheeler's Tonic Sherry Wine Bitters	18,8
Wheat Bitters	13.6
Faith Whitcomb's Nerve Bitters	20.3
Dr. Williams' Vegetable Jaundice Bitters	18.5

But perhaps the most astonishing part of the Committee's report was that upon the "opium-habit cures" (*sic!*). Dr. B. F. Davenport, the Massachusetts State Analyst of Drugs, furnished the Committee with the result of his examination of the twenty following "cures," *each and every one of which responded to the test for morphine:*

The "cure" of H. L. Baker, Toledo, Ohio.
" " " J. C. Beck, Cincinnati, Ohio.
" " " Chas. C. Beers, New York City.
" " " Geo. A. Bradford, Columbus, Ga.
" " " P, P. Bowzer, Logansport, Ind.
" " " J. L. Carleton, Chicago, Ill.
" " " S. B. Collens, La Porte, Ind.
" " " B. S. Dispensary, Berrien Spring, Mich.
" " " J. A. Dollinger, La Porte, Ind.
" " " J. R. A. Durn, Elizabeth, N. J.
" " " J. C. Hoffman, Jefferson, Wis.
" " " H. H. Kane, New York City.
" " " L. E. Keeley, Dwight, Ill.
" " " F. E. Marsh, Quincy, Mich.
The "cure" of L. Meeker, Chicago, Ill.
" " " Wm. P. Phelon, Chicago, Ill.
" " " Salvo Remedy, New York City.
" " " W. B. Squire, Worthington, Ind.
" " " J. L. Stevens, Lebanon, Ohio.
" " " B. M. Woolley, Atlanta, Ga.

He further examined "Kesley's Double Chloride of Gold Cure." It contained no gold whatever, but singularly no morphine. —*Quarterly Jour. of Inebriety*, Jan., 1890.

REPORT ON DISEASES OF THE EYE AND EAR.

BY A. T. MUZZY, M.D.

Williams (D. W.) an Indian Oculist.—Abdulkreen, the native oculist was under my care. After a few days he offered the opportunity of seeing his method of cataract extraction. On Nov. 8th, after his own recovery, the operation was performed. He seats the patient in a chair, the head being supported by an assistant. No anæsthetic is given, and yet very little pain was complained of. He then lightly fixes the eye by the thumb and index finger of the left hand and inserts the point of a strong narrow lancet, well guarded by adhesive cotton to within a line and a half of its point, into the sclerotic on the external side horizontally, two lines from the sclero-corneal margin and on a level with the lower border of the iris. A fine triangular-pointed probe five inches long, with a narrow neck about a fifth of an inch long and half an inch from the point to allow of freedom of motion without bruising the incisions, terminating in a rounded handle constituting the majority of its length of the same size, weight, and metal is then introduced by the thumb and first two fingers of the right hand in a semi-rotatory manner through the vitreous to the back of the lens. It is carried round and over its inner edge and brought rapidly and carefully to the front just behind the pupil. The capsule is then pierced by the probe, the lens depressed and drawn backwards and downwards in the same semi-rotatory manner. After holding the lens a second or so in the vitreous near the sclerotic opening it is withdrawn. This comparatively blunt needle seems to have a great advantage over the old couching needle, once the recognized instrument of cataract extraction. As the old needle, rather double-edged knife, was a very

dangerous instrument so near the zone of Zinn and ciliary body. Abdelkreen showed himself a dexterous operator, of coolness, nerve, delicacy and precision in manipulation fully equal to the first operators of the day, most of whom I have witnessed. He holds a diploma from the college of Lahore. A shovelful of cinders were used as aseptics and germicides, and a piece of heated brick wrapped in flannel was applied about the face and eye to relieve pain and inflammation.—*Brit. Med. Jour.*, Dec. 21, 1889.

Cheatham (W.) Acute Mania Following the Enucleation of an Eye.—The 30th of September last, a carpenter was struck on the eye by a spike six inches long, opening the globe at the inner sclero-corneal junction and also at the insertion of the external rectus. When first seen twenty-four hours later, considerable inflammation of the whole organ was present with conjunctival chemosis. Enucleation was performed the next day attended by considerable hemorrhage. The day following the operation there was great swelling of the orbital tissues with much pain, and mental excitement. The mental condition was that of acute mania for eleven days, the local inflammation continuing the same. As the swelling decreased the mental condition cleared. Pulse and temperature continued normal except that for twenty-four hours only, the temperature was $99\frac{4}{5}$. The condition may have been due to the dirt and rust introduced during the accident and the dirty handkerchief bound about the eye afterwards until seen the day after the accident.—*Arch. Ophthal.*, N. Y., Jan., 1890.

Thompson (J. H.) on a Remarkable Case of Detachment of the Retina; Recovery.—An electrician 25 years old was wounded while hunting, being accidentally hit in the face by shot from a companions gun. He noticed he was blind immediately. The day after the accident when first seen the right eye was found collapsed, filled with blood, and perforated in three places. The left was also badly damaged, partly collapsed, blood in the anterior chamber, and a shot wound of the outer inferior zone of the ciliary region from which exuded a bead of vitreous. He had fair perception of light and no sense of pain. A solution of bichloride of mercury was used but the following morning the right globe was removed on account of commencing panophthalmitis. In a week, healing of the external wounds was well advanced and the blood of the anterior chamber of the left eye absorbed, showing a clot about the internal wound of vitreous chamber; the vitreous being otherwise clear. Two weeks later bandages were removed altogether and patient able to read fine print. A few days afterwards examination showed commencing retinal detachment which progressed, in spite of every care, to total separation, and loss of all visual perception by slow but steady progress. Two months after accident he left the hospital, returning occasionally to have the irritation from the shot in the right orbit attended to. On appearing in June, 1889, about a year after leaving the hospital, I accidentally noticed the sensitiveness of the iris to light and shadow; but the patient perceived not a ray of light. Ophthalmoscopic examination showed nearly entire readjustment of the retina, and the disk and macula normal in appearance. Slowly light perception returned, and November 30th is able to read signs on the street, recognize friends when near, and were it not for a posterior polar cataract could read large type with a glass. With the ophthalmoscope the scar of the wound may be made out as a large crucial cicatrix and on the opposite side of the vitreous chamber may be seen another bright band in the retina.—*Arch. of Ophthal.*, N. Y., Jan., 1890.

Rolland (E.) on Sclerotomy for the Extraction of an Intra-Ocular Melanotic Tumor with Perfect Preservation of Vision.—The patient was a man of 32, strong and in perfect health. His only complaint was of a black tumor the size of a bean with a bosselated surface which projected from the upper inner quadrant of the sclerotic. The tumor had been growing twelve years, and was attributed by the patient to a blow on the eye by a twig.

The tumor was implanted about 6 mm. from the sclero-corneal junction, was closely adherent to the sclerotic from which it emerged and overlapped, without adhering to, the cornea, forced into this position by its own weight and by the contractions of the upper eyelid. The acuity of vision was normal. The motility of the eye toward the nose was limited.

An ophthalmoscopic examination re-

vealed, inside the eye, a reddish tumor the size of a large fly's head, situated directly under the external tumor and apparently a prolongation of it.

It seemed a pity to extirpate an eye which had perfect vision so it was determined to attempt an extraction of the tumor.

On March 1st, 1889, the eye was anæsthetized by cocaine and the operation field was rendered aseptic. The tumor was transfixed with a silver wire, the ends of which were twisted together and served to hold the tumor. An incision through the sclerotic was made, with a Græfe's knife, on each side of the tumor, making in all a cut of 4 mm. in length. The tumor was mobilized and extracted by side to side and torsion movements imparted chiefly by means of the silver wire, aided by a silver canellated sound. On extraction it was discovered that the internal was in no way connected with the external tumor. About one-third of the vitreous escaped during the operation.

The scleral wound was closed with catgut, the conjunctiva with silk. An antiseptic dressing was applied and left on for five days, an attendant moistening the part day and night every half hour, with iced borated water. On the sixth day the dressing was removed; no inflammatory action had taken place; the cornea and media were transparent and the vision was good. Seven months later no trace of the operation remained, and the patient was enjoying good health and perfect vision.—*Le Poitou Méd.*, Feb. 1, 1890. R. W. A.

Ford (V.) on a Proposed Surgical Treatment of Opaque Vitreous.—Among the most unsatisfactory cases as regards treatment and prognosis that seek advice at our various eye hospitals, those in which impaired or lost vision is due to the opacities of the vitreous form a considerable number. Unless such can be traced to specific disease, treatment is practically useless. The text-books do not even refer to the treatment of this serious condition, and I have never known a case which was improved by ordinary medical means. The causes of opaque vitreous, apart from the specific ones, which often do well under treatment are principally inflammatory conditions of the choroid, retina, and ciliary body, retinal hemorrhages, changes occurring in progressive myopia, chronic and subacute glaucoma. In cachectic or strumous states, where the general health is much impaired, I have noticed a haziness of the vitreous; but frequently this condition occurs without any apparent cause. To sum up, this morbid state of the vitreous is one of the most unsatisfactory as regards treatment and prognosis in ophthalmology. The form of procedure I now adopt, when it is is evident that the turbid condition of the vitreous is the principal obstacle to vision, is the removal of the opaque fluid by suction. The resected vitreous being naturally clear, the plan I adopt is as follows: Taking a hypodermic syringe with a large bore, I snip up a small piece of conjunctiva above or below the external rectus, the globe being held firmly, and rotated inwards with strong fixation forceps, either by the operator or an assistant. I then insert the needle at the point indicated, and draw off from ten to eighteen minims of vitreous, the amount depending upon its consistence and upon the tension and general condition of the globe. The number of operations necessary in each case will, of course, depend on the amount of fluid removed, the condition of the patient's health, and the amount of benefit following each tapping. I have now operated several times in cases of opaque vitreous with such good results as to warrant me in recommending its trial to others engaged in ophthalmic work. I hope shortly to tabulate these cases, some of which are under observation, but as an example I append a few notes of my last case.

Mrs. C., aged forty-four, otherwise in perfect health, consulted me at the infirmary about her right eye. On examination I found that she could only perceive light and shadow with the eye; no part of the fundus could be seen. After four operations at intervals of two or three days, during which no bad symptoms, inflammatory or otherwise, occurred, the vision of the right eye was equal to $\frac{3}{60}$, and she can see her way about well. Ophthalmoscopic examination revealed a very ragged fundus, atrophic patches, and general choroidal disease. The risks attending this operation are, as far as I have seen, very slight; but it must not be lost sight of that the punctured wound of the sclerotic cannot be inflicted with too clean an instrument, also that the withdrawal of too much vitreous

might be followed by a detachment of the retina and collapse of the globe. It would be hardly possible for any one with average skill to injure the lens or other delicate structures of the eye. No doubt further experience is required before ranking this amongst firmly established operative procedures; but I trust that these few notes may possibly induce others to adopt a form of treatment which occasionally gives brilliant results, and is particularly free from risk.—*Lancet*, March 1, 1890.

R. W. A.

Burnett (C. H.) on Aural Vertigo Entirely and Permanently Relieved by Excision of the Membrana Tympani and the Malleus.—From the author's case we learn:

1. That tinnitus and aural vertigo may be due entirely to disease in the middle ear, and therefore should not be referred always to a lesion in the internal ear.

2. The tinnitus and vertigo were evidently caused by the impaction of the stapes in the oval window and pressure on the labyrinth fluid induced by the retraction of the malleus. The removal of the latter liberated the stapes, and relieved the tinnitus and vertigo caused by its inward pressure upon the fluid of the vestibule and mediately upon the peculiar nerve-fibres in the semicircular canals.

3. The deafness which still exists is probably due to atrophy of auditory nerve-fibres, from long-continued compression exerted by the compromised lymph in the labyrinth.

4. It is also seen that nothing but good resulted from the operation in this case, and that the benefit is still maintained after a lapse of sixteen months. We may therefore conclude that this would always be the result in a case with similar indications for the operation. If a discharge sets in after the operation, it is easily checked. Excision is almost invariably followed by the formation of a new membrane. The latter has no retractive power, however, as it possesses no ossicular connection with the middle ear. Hence, the new membrane is attended by no return of tinnitus or vertigo.—*Am. Jour. Med. Sci.*, Feb., 1890.

Lopez (E.) on Ocular Leprosy.—Over half the lepers at the hospital of San Lazaro in this city (Havana) suffer from some form of eye trouble; and including the eyelids, every leper is sure sooner or later to show signs of the disease here. Of eighty-two patients noted, the disease is localized in the eye in forty-five, and include all races, but showing by far most frequency in the Chinaman and least in the negro. As to sex, thirty-eight were male and seven female, showing a remarkable difference between the sexes. Almost all the patients acquired the disease in adult life. In infancy leprosy is no doubt rare. Almost every leper will find his eyelids attacked at the beginning of his illness, either by anæsthetic patches, or tubercles, or deformities of the lid outlined by destruction of the eyelash follicles. *Anæsthesia.*—Sensibility is lost in patches, which have a slightly different color, but without any apparent deformity. Over the patch the temperature is lower and the glandular elements of the skin are destroyed, causing the dry, dull appearance quite characteristic of the disease. *Tubercles.*—These are quite frequent in the lids and if agglomerated together, as in lionthiasis or tubercular deposits over the face, this region being enlarged the eyes look small and sunken. As so often occurs in other leprous disorders, tubercular infiltration of the eyelids is liable to be symmetrical. When tubercular deposits become large ptosis is induced from the volume and weight of the lids. *Madarosis.*—Loss of eyelashes and eyebrows takes place early in leprosy, and first draws attention to the patient. This is in marked contrast to the scalp, where, in all patients, the hair is preserved, and is abundant and of natural color to the last. The hairs of the eyebrow and lid fall out singly or in groups following anæsthesia and destruction of their follicles. The progress of this lesion produces changes in the direction of the hairs or distichiasis. *Ectropion* is often met in the nervous and mixed forms of leprosy, always of the lower lids, and is due to paralysis of the orbicularis palpebrarum. Entropion is rarely met with. Epiphora is not an attendant on the ectropion of leprosy. *Conjunctiva.*—Leprosy produces the alterations of anæsthesia, inflammations, pterygium, and tubercle in that membrane. Anæsthesia produces complete loss of sensibility in this usually very sensitive region. It is frequent in all forms and constant in the nervous. Conjunctivitis is due to either anæsthesia or tubercle. Under anæsthesia the membrane is subjected to constant irritation, and so

the resulting inflammation proves most obstinate from the difficulty of effectually protecting the eyes from dust, acrid vapor, and, in hot climates, flies. The inflammation is accompanied by active hyperæmia, some photophobia, and rarely by scanty mucous secretion. If ectropion exist, the conjunctivitis is made the more intense and obstinate. Pterygia are frequent, and from ectropions of the lower lid are at times vertical, corresponding to the exposed portion of the globe. But the larger number affect the position taken from other causes, viz.: the horizontal meridian. *Leprous tubercles* develop in the conjunctiva as in the skin. And the point of election is the sclero-corneal juncture. It appears as a white or pinkish pimple, which progresses surely and without fail to the total destruction of the globe. *Cornea.*—Changes here are frequent and varied. And when blindness comes on it is from changes in this membrane. Anæsthesia is as marked a symptom here as in the conjunctiva. *Tubercles* start from the corneal tissue, as well as from the conjunctiva. Usually in the lower half of this membrane a little white spot appears without any inflammatory reaction of the conjunctiva, so distinguishing it from leucoma. This slowly and steadily spreads and then thickens, and, finally, from exposure and constant irritation, breaks down in ulcers with fetid discharge. This leprous keratitis is a late manifestation of the disease and is frequently symmetrical, although generally at a different stage of development in each eye. This form of keratitis is much like the syphilitic in appearance. But the history and attending symptoms make the diagnosis. While in syphilitic keratitis the commencement is at the centre, the leprous is from the margin, affecting the centre last. The syphilitic is accompanied by lachrymation, conjunctival injection, and intense photophobia, while the leprous is indolent, silent, and without reaction. *Sclerotic.*—Tubercle in the form of inflammation in the sclera. It at first appears much like a rheumatic episcleritis. But as general leprous lesions always precede this particular form, it is easily diagnosed. And besides, this form of scleral inflammation has more tumefaction of conjunctiva and sclera, with the usual anæsthesia. It is habitually located in the infero-external quadrant. *Iris.*—This membrane is affected in half the cases noted, and there is no doubt it always appears during some of the stages of the general disease. Iritis may commence as inflammatory or tubercular. The tubercle affects any point. Its course is insidious, and is rarely an early manifestation. The iris always shows a darker color, is roughened, myotic, and indolent or wholly inactive to light. This iritis, from abundant plastic exudation, produces many synechiæ It is recurrent, and the first symptom is myosis. *Crystalline lens* changes are secondary to changes in the iris and ciliary body, and are not frequent. *Deep membranes* are rarely affected except in late stages and as secondary to progress of disease in the external portions. *Treatment* should be preventitive and protective, mindful of the anæsthetic condition. Isolation, rooms arranged to protect against irritating vapors and dust; eye-glasses. Ectropion should be corrected by plastic operations, for lepers heal from these procedures very readily. Otherwise cleanliness by use of boric-acid solution or bichloride of mercury, and atropine for iritis.—*Arch. Ophthal.*, N. Y., December, 1889.

MISCELLANY.

Statistics of Leprosy in the United States.—In view of the general impression that leprosy is spreading in this country, it is desirable, in the interest of the public health, to obtain accurate information upon this point. The undersigned is engaged in collecting statistics of all cases of leprosy in the United States, and he would ask members of the profession to aid in this work by sending a report of any case or cases under their observation, or coming within their knowledge.

Please give location, age, sex, and nationality of the patient, and the form of the disease—tubercular or anæsthetic; also any facts bearing upon the question of contagion and heredity.

Address Dr. Prince A. Morrow, *Journal of Cutaneous and Genito-Urinary Diseases*, 66 West 40th Street, New York.

Terrillon on Trephining the Ilium for Deep-Seated Pelvic Abscess.—The subject was a young girl who had many fistulas consecutive to abscesses, having their origin at the anterior superior spine of the ilium, and seated in the fold of the groin. An incision from the crest of the ilium revealed a purulent cavity

between the peritoneum and the iliac fossa and also a prolongation into the true pelvis. The abscess cavity was thoroughly cleared out and a counter opening made below Poupart's ligament.

A few months later, the sinus having reformed, Terrillon cut down on the iliac bone and made a small trephine opening through it behind the cotyloid cavity, and, after thorough irrigation, introduced a large stiff drainage-tube. In thirty-five days the cavity was closed up and the tube removed, and in five months the patient was perfectly well.

Terrillon performed the same operation in 1888 for psoas abscess with complete recovery in four months.—*La Tribune Méd.*, Nov. 14, 1889.

A Discussion on Electrolysis in Urethral Stricture.—At a recent meeting of the Medical Society of London Mr. Bruce Clarke reported fifty cases of urethral stricture and the results of their treatment by electrolysis. He claims that the process is not in reality a destructive one. It consisted in modifying and softening the cicatrices by which the strictures were produced, a fact which could be witnessed by any one who would take the trouble thus to treat a stricture of the urethral orifice. Some of the cases could not, he thought, be explained merely on the theory of absorption. He mentioned one case, in which an ulcer was present, where electrolysis produced a rapid cure. He cited instances to show that just as it had been shown that a rectal stricture might begin by spasm of the muscular fibres, so urethral stricture could, and often did, begin in a similar fashion, an irritable ulcer being the starting-point. The caustic alkali, liberated by the negative pole of the battery, cured the ulcer, and thus relieved the muscular spasm, whilst if it failed to cure the ulcer it might, in rare cases, aggravate it, and so intensify the stricture. Some instances of this kind were related. Of the fifty cases, twenty-three were known to be well after periods varying from one and a half to three years, and in two cases no relapse had taken place after four years, whilst only nine were known to have required subsequent treatment.

Mr. Reginald Harrison said that his experience of treating stricture by means of electrolysis was not great, but what he did know of it was not in favor of the method. He had seen a number of cases which had been submitted to electrolysis in this country and in America, but none of them had increased his regard for this plan of dealing with stricture of the urethra. The amount of thickening that had taken place in these cases was very considerable, though whether this was incidental to the stricture or to the treatment employed he was not prepared to say. He had never met with a patient who expressed unbounded confidence in the treatment, and the results, so far as he had been enabled to observe them, were not of a nature to encourage him to extend its use. He much preferred gradual dilatation, and he had had no reason to complain of want of success by this method.

Mr. Hurry Fenwick alluded to his own experience of stricture of the urethra, and said that in twenty cases in which he had tried the electrolytic treatment, they were all considerably worse after than before the treatment. Thinking his plan might be faulty, he had applied to Dr. Steavenson for advice and counsel, but without any improvement in the results obtained. He pointed out that the treatment was by no means devoid of danger, and he quoted instances in which the electrode had been pushed into the rectum, etc. He also mentioned one case in which the fatal result was attributed to this method. He said that only certain forms of stricture were amenable to electrolysis, namely, those in the deeper parts of the urethra associated with spasm. He concluded with the remark of an American practitioner—"that the brilliant results said to have been obtained by electrolysis of stricture depended upon the credulity of the patient and the ingenuousness of the practitioner, or possibly upon some fortuitous act of Providence upon which it would not be safe to count."—*Brit. Med. Jour.*, Dec. 7, 1889.

Farrant on Dorsal Hip Luxation in a Child.—These are of sufficient rarity to furnish the following case with interest enough to make it worthy of recital. A boy of seven years stumbled and fell; on attempting to rise the left leg was found to be powerless. Examination showed the head of the femur to rest on the dorsum ilei, the great trochanter to be above Nelaton's line, the ball of the great toe resting on the dorsum of the opposite foot. Reduction was easily effected by Bigelow's method, the head of the bone entering the acetabulum with an audible click.—*Lancet*, Oct. 12, 1889. C. A. P.

Patteson (R. G.) on the Pathology of Joint Bodies.—In the majority of cases loose bodies of mixed bony and cartilaginous nature are *wandering osteophytes*, and are evidences of a latent rheumatic arthritis.

This form of chronic rheumatic arthritis is insidious and latent in character, occurs in young persons as well as in those more advanced in years, and is chiefly manifested in "lipping" of the articular margins, and in the formation of ecchondroses and osteophytes which, while attached, cause no symptoms.

These bodies, after liberation in the joint, may, and often do, undergo considerable increase in size, their nutriment being derived from the synovial fluid. This fact points to the necessity of their early removal by operative interference.—*Dub. Jour. Med. Sci.*, Feb., 1890.

Williams (T.) on a Case of Basic Tubercular Cavity.—A man, aged thirty-one, twelve years previously was the subject of left-sided pleurisy, and had had winter cough ever since. Considerable hæmoptysis occurred five months ago, and was repeated later, but the usual symptoms of phthisis were absent till about two months ago, when, on admission, a well-marked cavity was detected at the base of the left lung, and the sputum was found to contain tubercle bacilli. There had also been considerable pyrexia, and the apices of both lungs presented the physical signs of tuberculization. The author remarks that primary a basic cavity is exceedingly rare, and when it occurred was generally the result of the usually active movement and free ventilation of the lower lobe being interfered with by pleuritic adhesions, as in the present case, thus placing it under conditions similar to those of the upper lobe, the usual seat of tubercle. When a cavity formed at the base, it generally increased in size, owing to the ulcerative processes being promoted by the difficulty of expectoration. In the present instance it was impossible to say definitely whether the cavity was primary or secondary, the physical signs not absolutely precluding the presence of old tuberculated disease at the apices.—*Lancet*, Feb. 1, 1890.

Péan on Total Resection of the Bones of the Face.—The distinguished surgeon relates the case of a young woman, thirty-two years of age, who came to him with an enormous osteo-fibroma, involving the three maxillary bones. The left superior maxilla had attained the size of the head of a newly born child. At a first operation Péan removed both superior maxillæ through the usual incisions. Six weeks later he resected the lower jaw.

Primary union followed all wounds, and an ingeniously devised dental apparatus, fitted within the buccal cavity, permits the patient to retain the saliva, to speak, and to eat. Resultant deformity was comparatively slight. Péan concludes that the total ablation of the maxillary bones can be made with success, and that it is indicated in cases in which the three maxillæ are simultaneously involved in an osteo-fibroma. Also that deformity and functional troubles can be prevented by suitable frottetic apparatus.—*Gazette des Hôpitaux*, Jan. 16, 1890.

C. A. P.

Foster (John M.) on Fracture of the Frontal Bone.—The appended case is an interesting contribution to the subject of fractures through the base of the skull. The occurrence of blindness in these fractures was spoken of at length by Dr. Karl Koller, in a recent paper read before the Academy of Medicine in this city.

Male, aged fourteen years, on July 30, 1889, sustained a compound comminuted depressed fracture of the left lower part of the frontal bone, with rupture of brain membranes and contusion of brain substance. After removing several small fragments of detached bone, and one large fragment which was partially attached and depressed, causing convulsions, the brain was exposed from the inner angle of the right eye to a point one inch above the outer extremity of the left eyebrow, making an open space three inches by one and a half. A piece of the vault of the orbit was also removed, as it was detached. The wound was cleansed, and a bone drainage-tube inserted. The patient left his bed in ten days and has made a good recovery, with the exception of loss of sight in the left eye. There were two interesting features in the case: The larger fragment of bone removed contained the frontal sinus, which had a capacity of one and one half drachms, although writers say that this sinus does not begin to make its appearance until the age of fifteen or sixteen. The longitudinal sinus was torn across, but the bleeding from same was arrested without surgical interference.—*Am. Pract. and News*, Feb. 1, 1890. C. A. P.

BOOK NOTICES.

Education and Culture as Related to the Health and Diseases of Women.—By Alex. J. C. Skene, M.D. George S. Davis, Detroit, Mich., publisher. 1889.

In an exceedingly attractive little volume, Dr. Skene has ably discussed the question, of such vital importance at the present time, of whether education and culture harm women, and what are the defects in the modern system of the training of girls. Dr. Skene believes that much of the disease among women results from imperfect development, and urges strongly the symmetrical physical education, so lamentably absent from the public schools and higher private schools. The author, however, shows no familiarity with colleges for women, where at the present time are to be found the most approved facilities for physical culture, as well as its recognized place in the curriculum.

Dr. Skene very justly deprecates the painful lack of usefulness in the modern education of girls, and urges greater care in fitting them for their natural place in society, as home-makers and mothers. Co-education is condemned as well as teaching anatomy and physiology to young girls. The author gives some good advice about the early care and training of children, and closes his excellent little book with a wise and wholesome chapter on Rest. E. S. B.

Photographic Illustrations of Skin Diseases, an Atlas and Text-Book Combined.—By George Henry Fox, A.M., M.D., etc., etc. Hand-colored plates; nearly one hundred cases from life. 4to in 12 parts. Parts 9 and 10. E. B. Treat, New York.

Part 9 finishes the study of hypertrichosis and hypertrophy of the nails, onychauxis, and then takes up the subjects Albinismus, Leucoderma, Alopecia, Alopecia Areata, Atrophia-Pilorum, Trichorexis Nodosa, Atrophia Cutis, Keloid, and Fibroma.

Part 10 deals with the three varieties of Lupus Vulgaris, Verrucosus, and Erythematosus, Xanthoma, Neuroma, Telangiectasis, Nævus, Angioma, concluding with studies of Scrofuloderma and Lepra Maculosa and Tuberosa. The subject of Syphilis is commenced in this part, and it is to be hoped that the two remaining parts will give as scientific and artistic a presentation of cutaneous syphilis as the preceding numbers have of other diseases. The quality of the work in parts 9 and 10 is equal if not superior, to any thing yet published in this very valuable series.

The Physician Himself and Things that Concern his Reputation and Success.—By D. W. Cathell, M.D., Baltimore, Md. Ninth edition, revised and enlarged. 8vo, pp. 298. F. A. Davis, Philadelphia and London. 1889.

In commenting on this new and ninth edition of Dr. Cathell's extremely interesting and valuable book it need only be said that it should be in every physician's library, and the major part of its contents in every physician's head. Its precepts are applicable alike to old and young. The student fitting himself for practice should read it and lay the foundations for his future work, and *no* practitioner is so old in practice or experience, so worldly wise or punctilious on medical ethics, that he may not learn more wisdom and see, in the mirror Dr. Cathell holds up to him, the mistakes he has made and is still making. Another book so replete with good advice and withal such interesting reading the reviewer has never had the good fortune to find. A vein of dry humor pervades the work, but it is the knowledge of human nature manifested and the thorough appreciation of the dangers, disappointments, and trials of a doctor's life that chain the attention and command the respect of the reader. The work cannot be too highly commended nor too widely read.

A Treatise on Materia Medica, Pharmacology, and Therapeutics.—By John V. Shoemaker, A.M., M.D., Professor of Materia Medica, Pharmacology, and Therapeutics in the Medico-Chirurgical College of Philadelphia, etc., etc., and John Aulde, M.D., Demonstrator of Clinical Medicine and of Physical Diagnosis in the Medico-Chirurgical College of Philadelphia, etc., etc. In two volumes. Vol. I.—Devoted to Pharmacy, General Pharmacology, and Therapeutics, and remedial agents not properly classed with drugs. 8vo, pp. 353. F. A. Davis, Philadelphia and London. 1889.

The title of Vol. I., as given above, sufficiently indicates the scope of the book before us. In arrangement the book is unique, and we think highly commendable; in subject matter complete and progressive as the times demand.

The reputation of the joint authors should be and is a sufficient guaranty as to the excellence of the work. After general considerations on materia medica, pharmacy: pharmacology, including the classification of medicines, the authors take up the study of remedial agents not properly classed with drugs.

Electro-Therapeutics is the first subject treated, and although it *is* an important therapeutic agent, all essential points might be presented in less than 73 pp.

Next comes Oxygen, 26 pp.; Hydro-Therapeutics, 24 pp.; Masso-Therapeutics, 15 pp.; Heat and Cold, 21 pp.; Mineral Waters, 12 pp.; while shorter articles on Metallo-Therapy, Transfusion, Hypnotism and Suggestion, Earth-dressing, Baunscheidtismus, Climatology, Light, Music, Blood-letting, and Suspension concludes the volume. It is refreshing to see a little space (6 pp.) devoted to Blood-letting, a very valuable but much neglected remedy.

The next volume will be looked for with much anticipated pleasure as appealing more directly to practitioners, and more likely to bring out the talent of the authors.

Transactions of the Medical Association of the State of Missouri, at its Thirty-Second Annual Session, held at Springfield, Mo., May 21, 1889. 8vo, pp. 218. W. E. Carreras, St. Louis, Mo.

It is impossible to more than call attention to this *very* creditable volume of transactions. It contains twenty-two learned papers read by members at the recent meeting of the Association, with the discussion they elicited. The discouraging aspect of transactions such as these is that, although some of the papers are published elsewhere, many of them are lost to the medical world because of the necessarily limited circulation the volume has. As mirrored in the book before us the meetings of the Medical Association of Missouri must be very interesting and instructive.

THE MEDICAL ANALECTIC AND EPITOME.

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE.

EDITED BY R. W. AMIDON, M.D.

VOL. VII., No. 4. April, 1890. WHOLE No. 156.

LEADING ARTICLE.

Savage (G. H.) on the Warnings of General Paralysis in the Insane.—General paralysis is a disease of higher civilization, and its ratio is nearly the ratio of the high-pressure life of cities. It is rare in the highlands and wilds of Great Britain and Ireland, and was rare in the negro of the Southern States, but the Highlander, the Welshman, and the Irishman die of the disease in cities, and with freedom the slave has gained general paralysis. I am rather inclined to look upon general paralysis as a degeneration, a premature decay, and as frequently having a local origin. Speaking in the language of metaphor it seems to me that just as a pear may long remain ripe and not decay, yet a bruise or a slight superficial injury will start the process of decay, so the overwrought brain may but need a local injury, such as a blow, or a local change in nutrition, due to syphilitic or other vascular changes to set up the necessary process.

In diagnosing the earlier symptoms of general paralysis it must be fully recognized that extreme difficulty is often experienced in distinguishing between causes and early symptoms, for in many cases what may be causes of general paralysis are also often signs of the disease. My observations are based upon a series of nearly one hundred cases, which came under my notice whilst in charge of Bethlem Hospital, in which the friends of general paralytic cases had filled in a printed sheet of questions relating to the earlier symptoms. As a result of these observations, I have come to the conclusion that general paralysis is a degeneration rather than a specific disease, and is most commonly met with in middle-aged married men, inhabitants of cities, flesh eaters, and drinkers of alcohol. It is not common among the congenitally deficient, or among epileptics; it is a frequent follower of constitutional syphilis, especially if this disease has affected the higher nervous organs or their envelopes, and it is not uncommonly related to head injury or to causes of nerve-tissue disease, such as those produced by lead. In general paralysis there are two special forms of onset, the gradual and the sudden. In the gradual onset the finer social and the finer muscular adaptations fail, and the changes and weaknesses in mind and body gradually show themselves. In the cases with sudden onset there is nothing to warn until a sudden storm arises, which may assume the character of a convulsive seizure, or an attack of emotional excitement, or one of mania.

To start with the motor side, in many cases one meets with an account of early fatigue, which is often associated with indecision, doubt, and a tendency to look on the dark side of things, and even to hypochondriacal weakness. The feeling of fatigue may be related to muscular tremor or to muscular paresis. It is to be noticed, too, that ataxy may be the first symptom of general paralysis, or it may be a symptom of the disease occurring at any period during its progress.

If ataxy is part of general paralysis there will generally be muscular defect of the hands and tongue which is out of proportion to the progress of the ataxy, and the symptoms will be either those of exaltation or of hypochondriacal melancholia, whereas if the insanity be that of the ordinary ataxy it will be of the suspicious and "persecuted" type.

Temporary aphasia is one of the most

striking and by no means uncommon symptoms of general paralysis. In such cases the patient, without any real cause, or after slight excitement or fatigue, becomes aphasic. He may or may not have been faint at the same time. The aphasic attacks may recur ; and aphasia is usually marked before change in the handwriting, though this symptom is an early one in cases of general paralysis. Facial expression is very early affected, and friends often say that the patient appeared to develop a "fat face," due no doubt to a wiping out of the lines of the face. Ptosis and external strabismus are rare as symptoms of general paralysis, but common in the diseased process which ends in general paralysis. Syphilis plays an important part in general paralysis. If after a history of syphilitic cranial nerve lesion there are any signs of nervous instability, there is real reason to fear that general paralysis may be the result. Any local cranial lesions, but especially such as depend upon syphilis, may originate general paralytic degeneration. In a few cases temporary loss of sight or of feeling has been complained of, a condition which is comparable to the attacks of "petit mal" in epileptics ; but it is remarkable that the epileptic insane provide very few cases of general paralysis.

Along the sensory side my notes seem to show that neuralgia, headache, sciatica, rheumatic pains, and the like were almost universally recorded as having been noticed a year or more before general paralysis was recognized. Double sciatica is not a symptom to be overlooked, and if it is recurrent and associated with any change in habits or character, it is a warning not to be disregarded. Loss of sight of a temporary nature may be present, and may or may not coincide with optic neuritis. Affections of hearing, too, are not uncommon. Alteration in the senses of taste and smell are by no means rare, whilst hallucinations of the senses are very rare. Amongst the warnings of a more mental kind the gradual loss of power of social accommodation is one of the earliest and most marked. Memory for recent events and for engagements is defective ; loss of power of attention and want of persistence are very well marked ; restlessness may be of motor or of mental origin. There seems to be almost a special set of faults met with in early general paralysis ; stupid stealing and thoughtless indecency are the commonest forms. The instability of the patient is almost always marked by a readiness to be affected by stimulants or drugs, the early general paralytic easily becoming drunk and easily being poisoned. Changes of temper and character are probably the most common of all the changes which are noticed in early general paralysis. In health we give evidence of our education, and in general paralysis we witness to our organic nature. In rare cases only does true hypochondriasis long precede the well-marked physical signs of general paralysis, but alternations of buoyancy and depression are of bad import. The sudden outbreak of mania is a frequent precursor of general paralysis, and this is specially interesting when it assumes the form of acute delirious mania (grave delirium). In this, as in the cases of local lesions of the brain there seems to be a process which lowers the vitality of the nervous system, and renders it liable to degeneration. Vaso-motor troubles, too, may occur.

I may conclude by calling attention to the fact that warnings of general paralysis may be present for years, and that almost certainly they are present for a year at least before the symptoms induce even the sensitive specialist to scent out the disease. This is but the measure of our present ignorance, and it is for others to fill up the gaps. With a syphilitic history or the history of injury, do not neglect early fatigue, fainting, or other fits, loss of smell, vague optic-disc changes, unaccountable knee phenomena, headaches, neuralgia, sciatica, change of character, and progressive loss of the highest control ; be observant of, but charitable to, moral lapses, and do not forget the various forms of instability.—*Med. Press*, April 2, 1890.

MEDICINE AND PATHOLOGY.

Renaut on Chronic Essential Fragmentary Myocarditis. — Under this name the author describes a new cardiopathy, with definite symptoms and absolutely characteristic lesions, which consist in a softening of the interfibrillary cement substance, effacing the scalariform markings of Eberth and producing a fragmentation of the cardiac muscle. This lesion is never accompanied by any other lesion, and the fragment of muscle thus separated shows

no degeneration. There sometimes is in the protoplasm surrounding the nucleus a deposit of pigment more or less brownish, but in all other respects the fragment of muscle is normal. The heart is not hypertrophied nor dilated, nor is there any valvular disease. The coronary arteries are not obliterated, but the heart is soft, yellowish, and pits on pressure. The interfibrillary connective tissue is not increased in amount nor is there any cardiac stenosis.

The clinical signs of this cardiopathy, which is often an accompaniment of senility, are as follows:

An arhythmic pulse and cardiac impulse, without hypertrophy of the heart, giving a trace like a simple senile pulse and never showing characteristics of asystole.

These disturbances of pulsation show themselves under two principal forms.

1st. A false regular pulse. On the tracing the pulsations are seen to be not equidistant, although they may appear to be absolutely regular to the finger.

2d. A truly intermittent arhythmic pulse which gives a senile trace, often broken by true intermissions and reduplicated pulsations as in digitalis poisoning.

The apex beat is wanting and the area of precordial dulness is rectangular. The heart sounds are diminished in intensity and a post-systolic murmur is heard over the middle of the heart, is propagated in no special direction, is unstable, changes, appears and disappears without seeming reason. This cardiopathy is never complicated by asystole and patients die of syncope or rupture of the heart. This segmentary myocarditis is generally due to normal or premature senility and alcoholism. The treatment consists in the administration of diminishing doses of digitatis. —*La Tribune Méd.*, Feb. 20, 1890.

Truax (J. G.) on Ulcerative Endocarditis.—The author reports at length six cases in none of which was the disease primary and uncomplicated. The heart lesions were not always associated with heart murmur. The temperature and many of the symptoms were common with those of typhoid fever. In none of the writer's cases did the temperature rise above 104°. It was lower in the morning, higher in the evening. Meningitis was almost always present. Two cases were complicated with tuberculosis, one with pneumonia, one with pleurisy, one with hypertrophy of the heart, and the other was not examined sufficiently to be able to tell. Medicines, excepting hypnotics, seemed to have no particular effect. Fowler's solution of arsenious acid, quinine, and bichloride of mercury were tried. The heart was examined, and cultures made in three of the most malignant cases for micro-organisms; none were ever found. The writer still inclines to the belief that the disease has for its cause the infection of some germ.—*Jour. Am. Med. Ass'n*, March 29, 1890.

Turner on Gumma of the Heart.—In the wall of the heart was an extensive syphilomatous growth with a necrotic central tract. It surrounded and considerably contracted the infundibular part of the right ventricle ¼ inch from the pulmonary valve and projected into the left ventricle. The right coronary artery was patent, but the left was occluded by a thrombus, its walls being also much thick ened. There was a nodule the size of a pea in the right testis, but no other signs of syphilis discoverable; there was, however, a history of infection ten years previously. At the apex of the right lung, which was firmly adherent to the chest wall, was a fibroid tract enclosing a small cavity. The specimen was obtained from the body of a potman, æt. thirty-seven. He had for some years suffered præcordial pain, palpitation, and giddiness, increased four days before admission when he was nearly run over. His pulse was fifty-two, becoming slower until his death from syncope four weeks later, being forty on the day preceding. A rough systolic bruit was heard at the base and cardiac dulness extended to the right. —*Med. Press*, March 26, 1890.

Duponchel on a Little Known State of the Peripheric Veins (Chronic Induration).—There exists in the patient in question an induration of certain peripheral veins which feel under the finger like an atheromatous artery. It is a chronic affection with acute exacerbations. It was first observed in 1881. The subjects have no varices nor hemorrhoids and in the acute stages have no œdema of the extremities nor general disturbance. In a single case there was cyanosis of the extremities.

It never completely closes the lumen of the vessel as does endophlebitis. A theory of periphlebitis is more tenable, but the author thinks it more like arterial atheroma.

He has twice seen arthritis in the patients. One patient had had alcoholism, syphilis, and malaria. Letulle has seen the disease in a consumptive.—*La France Méd.*, March 7, 1890.

Bidwell (W. D.) on a Case of Slow Pulse.—A married man seventy-one years old, was a stout able-bodied carpenter when he entered the cavalry service of the army in 1861. His pulse previous to that time was from sixty-five to seventy beats a minute. None of his family ever had rheumatism. His father died at the age of eighty-seven, while his mother died when forty-five or fifty. His only brother was seventy-three when he died. In the spring of 1864 Mr. M. had an attack of inflammatory rheumatism which confined him to the bed two or three months, and a second attack in December of the same year lasting about the same time. Since then his heart has not been perfectly sound. In 1881 he fell on the street in Chicago, was taken up for dead and carried to a doctor's office where he revived and was sent to the hospital. He was there told that he had heart disease, and his pulse at that time was said to be very slow. At present his limbs are somewhat atrophied from lack of use and old age, pain in the joints making him keep rather quiet. If he attempts to walk he staggers and frequently falls, sometimes in an unconscious condition. There is but a moderate degree of hypertrophy, although a systolic murmur, loudest in the third intercostal space and one inch to the left of the sternum, transmitted equally up and down, indicates the existence of aortic stenosis or obstruction. The pulse at present is thirty-five, and in the last few months has varied from this down to twenty-four beats to the minute. The rate of thirty-five has not been exceeded for some years.

Of course this rate is the mark of a pathological condition in this case, but there are few cases on record, pathological or physiological, where as slow a beat has continued for any length of time.—*Kansas Med. Jour.*, April, 1890.

Classen (F. L.) on Pyæmia; A Sequel to Gonorrhœa.—W. S., aged thirty-two years, stoutly built, came to my office having gonorrhœa. Nothing was given to arrest the discharge, but he was treated antiphlogistically. At the end of a week I was called to the patient's house, and found him presenting the following symptoms: headache, pains through both wrists and finger joints, also over sterno-clavicular articulations; temperature 102°; discharge from penis stopped. A diagnosis of gonorrhœal rheumatism was made, and the salicylates and potassium iodide prescribed. He seemed to be doing nicely during the next two weeks; temperature became normal, and he was apparently on the road to recovery; but at the beginning of the third week the aspect of the case changed, and he had recurrent chills, profuse sweats, great thirst, hurried respiration, anorexia; temperature ranged from 104° to 106°, with but slight remissions. From this time on, the temperature continued high, tongue became dry and brown, delirium followed, bed-sores formed, and at the end of the fourth week he died. The discharge from penis returned three days before death. No post-mortem held. *Albany Med. Annals*, March, 1890.

Féréol on Calculous Anuria Lasting Eight Days and Followed by Recovery.—A man of forty-nine with gouty heredity, but in whom the disease had not shown itself for twenty years, had in the space of two months two attacks of anuria lasting twenty-four hours, preceded by vague pains in the loins and hæmaturia, followed by the emission of clear albuminous urine, and a small uric-acid calculus.

Recently after similar prodromata he had a third attack lasting eight full days. He passed perhaps twenty drops of dark urine in all that time. The anuria ceased abruptly, and in twenty-four hours the patient expelled ten litres of watery urine, containing 170 grams of urea, with which came away one uric-acid calculus, the size of a pea, and many small ones. During the eight days there was slight pain in the right side; the bladder was empty. The sole indications of uræmic poisoning appeared in the last two days of the attack, and consisted in a slowing of the pulse to fifty-two, and a rectal temperature of 98°.

The treatment consisted in dry cups to the lumbar region, electrization morning and evening, inhalation of five quarts of oxygen daily, ingestion of a quart and a half of milk, a pint of Vichy, a pint of a strong alkaline mineral water, and a diuretic potion daily. On the fifth day fifteen-minute baths. The seventh day purgation was resorted to. Five grains of caffeine had been given on the morning of the eighth day.—*L' Union Méd.*, Feb. 20, 1890.

Spanton on Epithelioma on Site of Specific Ulcer.—A married woman, aged thirty-three, first consulted him in June, 1889, with an ulcer on the anterior lip of the uterus, which, as she had an undoubtedly specific sore-throat, was diagnosed to be syphilitic and treated accordingly. It healed up in a week or two, but about two months since an ulcer, with every appearance of malignancy, was seen on the site of the previous ulcer. It was removed and microscopic examination showed the characteristic "nests" of epithelioma.—*Brit. Med. Jour.*, March 15, 1890.

Verneuil on Scrotal Pneumocele.—This disease presents many varieties:

1. According to the location of the gas: (*a*) subcutaneous pneumocele, (*b*) vaginal or serous pneumocele.

2. According to the chemical composition of the gas: (*a*) aërial pneumoceles, containing atmospheric air; and (*b*) bacterial pneumocele, whose gas is air mixed with putrid gases.

3. According to the way in which the gas reacts on the tissues containing it, or on the whole system: (*a*) benign pneumocele, and (*b*) malignant or septic pneumocele.

In short, the two principal forms are:

1. The benign, aërial, scrotal pneumocele, located in the subcutaneous connective tissue or vaginalis.

2. Malignant, bacterial, scrotal pneumocele, located in the connective-tissue spaces or peritesticular serous sac.

These pneumoceles are never idiopathic, but are always preceded by a local or distant lesion. The local lesions are wounds of the scrotum, with introduction of atmospheric air, hydroceles, or hematoceles, in which gas appears spontaneously, or after puncture with a trocar.

Distant lesions may be: (1) Wounds of the air passages and cavities adjacent to the head and neck; (2) wounds of the intestine in the abdomen, the ano-rectal region, or about a hernia; (3) wounds, of any location, complicated by aërial or bacterial emphysema, the gas of which may infiltrate the scrotum; (4) phlegmons of every nature seated near the male genital apparatus.

In aërial pneumocele the prognosis is good, and simple puncture is the treatment.

In bacterial pneumocele, phlegmons form with severe inflammatory œdema, and even gaseous gangrene. Treatment must be prompt and energetic, free incisions, and even scrotal resections, and even castration in old complicated cases.—*La Tribune Méd.*, March 6, 1890.

Bertrand on Perihepatic Friction Sound.—The author has called attention to a very valuable sign of abscess of the liver, viz.: perihepatic friction sound (*frottement périhépatique*), not described in text-books. This perihepatic friction is perceived by the ear and by the hand applied to the right hypochondrium, more frequently at the level of the seventh or eighth intercostal space, on the anterior axillary line, which would appear to indicate the peritoneal origin of the lesion. This sign is the more important as it may precede by several days œdema of the part. The perihepatic friction sound is, moreover, proof that the liver is fixed to the abdominal walls by the peritoneum, knowledge of which is not without importance to the surgeon. In general this friction is found at the level of the point where the maximum of pain is felt. It is also at this point where parietal œdema occurs, which would indicate the spot where any exploratory puncture should be made. The author concluded his note with the advice that in an individual presumed to be affected with abscess of the liver, auscultation should be employed, not only over the respiratory organs, since thoracic migration of pus may have taken place, but also over the liver, to aid in diagnosing the hepatic abscess.—*Lancet*, March 15, 1890.

Keuster on Lead-Poisoning from a Bullet.—In the year 1870 a man received a bullet in the tibia, and it was allowed to remain in the wound. In 1888, without known cause, he was seized with violent colicky pains, accompanied with constipation. There was a blue line on the gums, tremor and clumsiness of the hands, and lead in the urine.

The cicatrix was reopened, and the periosteum and bone explored, with the result of finding the projectile reduced to fine particles, recognizable only by the microscope, their exact nature, however, being determined by chemical analysis. All suspected parts were scraped and removed with immediate improvement of symptoms. —From *Rev. des Sci. Méd.* in *Jour. de Méd. et de Chir. Prat.*, Feb., 1890.

Jacobson on the Surgical Sequelæ and Complications of Fevers.—The author thought that diseases of the peri-

osteum and bones were not of very rare occurrence after an attack of typhoid fever. In his own experience the ribs had been more frequently attacked than the bones of the lower extremity. He considered that the causes were various, the chief perhaps being thrombosis, enfeebled nutrition, weakened periosteum due to a strumous taint, or, where the disease ensued long after defervescence, some muscular strain. In obstinate cases the treatment should not be of too expectant a nature. Amongst diseases of the joints, dislocations and ankylosis were the most common. Phlebitis and its consequences, too, he had frequently met with, and he narrated several interesting cases. Gangrene was of importance, especially when it affected the genital organs, for it might easily be overlooked or mistaken in its earlier stages for other diseases. Pleuritic effusions following upon typhoid fever were remarkable for the insidiousness of their onset and for their liability to suppurate. Abscesses were of three kinds: those which were superficial and were akin to boils, those which were glandular, and those which started in hæmatomata. Laryngeal troubles were of disputed frequency, and Mr. Jacobson believed that they occurred more often in some epidemics than in others. Parotiditis was of interest not only on its own account, but because, as Mr. Stephen Paget had shown, it might be associated with any form of abdominal lesion. Orchitis was said by Hanot and other French observers to be a complication of typhoid fever, but Mr. Jacobson had not yet met with any case. Dr. Sidney Phillips, in the discussion of the paper, alluded especially to the complications of typhoid fever. He had seen cases of periostitis of the tibiæ both in men and women, and he thought that periostitis of these bones was of more common occurrence than periostitis of the ribs. Bedsores he considered to be a much less common sequela than it was formerly, a change which he attributed to the improvement which had taken place in modern nursing. He narrated an interesting case of a fatal outbreak of typhoid fever occurring amongst some dairy farmers who had eaten the flesh of pigs which had died of swine fever. One of the patients had cancrum oris. He had recently seen three cases of laryngeal trouble, one occurring in an outpatient, and all in male adults. He believed that cystitis and vesical hæmaturia were also sequelæ of typhoid fever, and that their cause was too often overlooked. Mr. Morgan thought that "quiet dislocations" were not uncommon as a result of fevers, and he narrated cases in which such dislocations had occurred after measles and acute rheumatism. Dr. Goodhart had seen two cases of plugging of the venæ cavæ, due to typhoid fever. He considered that such thrombosis might perhaps be explained by assuming that typhoid deposits occurred in the vascular system, just as they were known to occur in the kidneys, where they gave rise to a peculiar form of albuminuria. He explained the frequent association of measles and joint disease by saying that severe measles was a very bad fever, and left the patient in a very low condition and a suitable nidus for germs.—*Lancet*, March 8, 1890.

Ballet (G.) on Ideas of Persecution in Exophthalmic Goitre. — Disturbances of intellect, among other nervous troubles, have already been observed in exophthalmic goitre. Ballet seeks to prove that external ophthalmoplegia, polyuria, glycosuria, and perhaps some epileptiform attacks do not constitute the entire symptomatology of goitre; but, on the other hand, that paralysis of limbs, epileptic crises, various other troubles of sensibility and motility, hysteria, chorea, and locomotor ataxia, also form a part of Basedow's disease. The author now reports a case of Basedow's disease with delirium of persecution, and seeks to show the genesis of these ideas.

Mistrust is the dominant characteristic of this patient. He imagines that everybody watches him, but singles out three persons, of which the author is one, who persecute him particularly. The patient has hallucinations of sight, hearing, and smell.

The patient is hysterical, and the author thinks the hallucinations are a part of the hysteria, but he contends that the ideas of persecution are evolved from the hysterical hallucinations by the exophthalmic goitre.—*La France Méd.*, March 7, 1890.

Beevor on Athetosis Involving the Face.—The patient was a man aged twenty-seven. Two years ago he fell down-stairs, striking the left side of the head. He was unconscious for ten minates; on recovery he noticed that he had movements in the right thumb and in the right side of the face. A week later movements com-

menced in the fingers, a fortnight later in the elbow and shoulder, and four weeks later in the lower limb in the order of hip, knee, and foot. There was no anæsthesia and no aphasia. At the present time he had partial paralysis of the right side of the face; there was marked athetosis of the right hand, and at times involuntary movement of the elevator of the right upper lip. There was no absolute paralysis of the right upper limb; there were stiffness and slight movements of the right foot; there was no tenderness or pain over the head. The case was important as occurring after injury, and also that the order of invasion corresponded to the arrangement of the different parts on the cortex. He thought the lesion was probably a hæmatoma on the cortical area over the region of the centres of the face and thumb. The movement of athetosis occurring in the face was very unusual. The treatment recommended was trephining over the centre for the face and the elevator of the upper lip.—*Lancet*, March 22, 1890.

Foxwell (A.) on a Case of Tuberculosis with Rupture of a Caseous Nodule into the Pericardium.—A man, aged thirty, was admitted, November 14, 1889. He died on December 1st, and on the 4th a post-mortem was made. His father died of consumption at forty-eight; otherwise his family history was very good. He remembered no illness till a year ago, when his left leg began to swell and remained swollen for three weeks. He suffered from a cough on and off for six months. He first stated that his illness arose from an injury to his ribs, due to a fall which he sustained ten weeks before admission, and after which he suffered from very severe pain in the side as well as from shortness of breath. The pain left him completely, but the dyspnœa increased, and a month ago his abdomen began to swell, followed a fortnight later by œdema of the legs.

On examination, there was a questionable blue line on the gums, with a thick cloud of albumen in the urine. The breath had the peculiar uræmic odor. There were considerable ascites and œdema of the legs. The spleen was not felt, but the liver had a firm, regular outline, and reached about an inch below the umbilical level in the right nipple line. There were the usual signs of moderate effusion in both pluræ, with rhonchi and sibili heard throughout the chest. The upper part of the left lung gave also a deficient percussion note, and the breath sounds were feebler than on the right. The heart sounds were feeble but normal; sticky decrepitations were heard over its area, but these were pleural in rhythm: the organ itself seemed enlarged, but its condition was masked by the state of the left chest. The artery was thick, the pulse 132 and irregular.

On my next visit I found the œdema quite gone from the legs and the ascites much less; the albumen had gone from the urine, and this had a fair amount of urea (two per cent.), while the specific gravity had been constantly 1020 or above, and no casts and epithelium, etc., had been found. Still the patient seemed but little better; there were muco-purulent blood-stained sputa, and the respirations were in excessive ratio (42 to 132); the temperature too maintained its height and was of the continued form (100° to 102°).

A fresh examination of the chest now revealed at the right apex impaired resonance both anteriorly and posteriorly, and reaching in front as low as the fourth cartilage; over this area the breath sounds were bronchial, and there were numerous fine crepitations and rhonchi. A few days later the dulness on the left side reached up to the second cartilage. Over the upper part of this dull area extensive pleural friction was heard, while at the third left space the friction was pericardial.

At the post-mortem each pleura contained about a quart of serous fluid. The apex of the right lung was much puckered and contained several foci of softening caseous nodules and one or two pea-sized cavities of recent formation. The remainder of the upper lobe was pneumonic and had many groups of tubercles in various stages of development, but all recent. The lobe was very œdematous and had rosettes of recent tubercle. The upper lobe of the left lung was thickly studded with groups of miliary tubercle. The lower lobe was collapsed. The pericardium was much thickened, $\frac{1}{32}$ to $\frac{1}{10}$ of an inch. It was lined with flocculent blood-stained lymph upon villous granulations. Its cavity contained a pint of fibrinous fluid.

There was general adhesive recent peritonitis and perihepatitis with little serous effusion, and all over the visceral layer of the peritoneum were multitudinous recent

tubercles. The great omentum was a quarter to half an inch thick. The liver was large (5½ lbs.), and extremely fatty, but had no tubercle. The kidneys weighed 6½ and 7 ounces; they were congested but otherwise appeared normal. The spleen was congested. The left lung, left pleura, and left side of the pericardium were all adherent to each other. In the lung border, and communicating by a small opening with the pericardial sac, was a broken-down caseous nodule the size of a horse-bean; this nodule was definitely encapsuled.—*Birmingham Med. Rev.*, March, 1890.

Dache (J.) on Tubercular Ulcers of the Duodenum in a Case of Tubercular Pulmonary Phthisis.—The subject was a young girl whose lungs were unequally affected. One showed tubercles throughout, united in nodules, more or less grayish, but very little degenerated; the other showed, in different lobes, cavities surrounded, particularly in the upper part of the lower lobe, by an extensive zone of gray hepatization. The pleura here was the seat of fibrinous deposit.

The intestinal lesions in this case were peculiarly situated. In most cases the disease is low down in the bowels, particularly about the ileo-cæcal valve, the acidity of the gastric juice preventing the implantation and propagation of the germs higher up. In the present case, however, the alterations were present nearly up to the stomach.

On opening the abdomen there was seen along the lymphatic vessels a tubercular infiltration surrounding the intestine in a network of small whitish nodules.

On opening the intestines, numerous nodules, containing tubercle bacilli, were found in the first part of the duodenum. In the second part of the duodenum were found, beside tubercular nodules, tubercular ulcers, and in the third part nodules again. From this point down to the descending colon, tubercular ulcers were frequent.—*Annales de la Soc. Méd.-chir. de Liége*, Feb., 1890.

The Influence of Gastric Juice on Pathogenic Germs.—Drs. Kurlow and Wagner, in a paper on the "Influence of Gastric Juice on Pathogenic Germs," which they publish in the *Vrach*, describe some interesting experiments which they have made on this subject, from which they are led to the conclusion that constant or specific microbes do not exist in the stomach, and those which enter it, together with sputum, food, or other ingesta, are only accidental and temporary residents, and cannot live in the normally acid contents of the stomach. Gastric juice is, according to the authors' experiments, an exceedingly strong germicidal agent, and when living bacilli get into the intestinal canal it is due to various conditions entirely independent of the gastric juice. When the latter is normal and in full activity, only the most prolific microbes, such as tubercle bacilli, the bacilli of anthrax, and perhaps the staphylococci, escape its destructive action; all others are destroyed in less than half an hour. Similar influences exist in the intestines, as proved by inoculations with the cholera bacilli. On the latter subject the authors intend making further experiments.—*Lancet*, March 22, 1890.

Schmidt on Primary Carcinoma of the Right Tonsil; Sudden Death.—A man of seventy-two, with no cancerous antecedents, had had, since August, 1886, a persistent sore throat. The symptoms were pain, alteration of voice, dysphagia, dyspnœa, lessened acuity of hearing, and fœtid breath. The tumor had become as large as a pigeon's egg. Death occurred suddenly. The author attributed death to syncope, from bulbar anæmia or detachment of a piece of the tumor which acted as a foreign body.—*La Tribune Méd.*, April 3, 1890.

Dowd (C. N.) on the Etiology of Influenza.—From a careful perusal of the literature on the bacteriology of influenza, the author concludes that in three series of observations, embracing about thirty cases, diplococcus pneumoniæ of Fraenkel-Weichselbaum was the predominant form; in six series, embracing sixty or more cases, streptococcus pyogenes was the predominant form; in four series the reports leave us somewhat in doubt about the predominant form. Both the diplococcus pneumoniæ and streptococcus pyogenes were found in the lungs, sputum, and other secretions, and in various exudations, and each was many times found in pure culture; *e.g.*, in the pus in otitis media Finkler finds pure growths of one, and Levy finds pure growths of the other. Both of these forms are found in the mouth and air-passages in health, or conditions of slight disease, and they seem ready to set up their action when inflammation provides a suitable medium for growth. The general

belief is that they have not been the cause of the influenza, but that they have developed as the influenza has provided them with a suitable condition for growth, and that their development may have caused some of the complications.—*Med. Record*, March 29, 1890.

La Nona.—We are still without reliable data as to the nature and pathology of the new (?) disease which is reputed to have followed in the wake of the epidemic of influenza in various parts of Europe. One in three of the cases are said to have proved fatal, but this is probably an exaggeration. According to the opinion of the medical authorities of Vienna, *la nona* is merely a new name for the comatose condition into which people sometimes fall when not possessed of sufficient recuperative power to rally from the intense prostration of that disease. The prolonged somnolency and final coma which are the characteristics of nona chiefly affect persons who have resumed laborious occupations before being thoroughly convalescent from an attack of influenza.—*Med. Press*, March 26, 1890.

The Alleged "New Disease."—About a week ago reports were received from Rome and Vienna of the appearance in the northern provinces of Italy, and subsequently in Hungary, of cases of lethargy or trance, termed by the country folk "La Nona," amongst individuals who had previously passed through a severe attack of influenza. The information at present received is far too scanty to admit of any surmise as to the nature of these cases, or to judge of the extent of its occurrence. It must suffice to observe that it has been long known that certain cases of influenza are accompanied more or less by severe symptoms of nervous disorder, and exhausting diseases, as typhoid fever, have been occasionally followed by the condition of trance. Among the negroes of the west coast of Africa there have occurred cases of a curious but highly fatal "sleeping sickness," concerning which but little is accurately known. On the other hand, it must be borne in mind that amongst susceptible subjects the condition of spontaneous "trance," which is obviously allied to the hysterical state, may occur amongst groups of individuals and be spread in a so-called "epidemic" manner, like the nervous affections of which Hecker wrote so instructive an account.—*Lancet*, March 22, 1890.

Kidd (P.) on Subacuate Indurative Pneumonia.—The author in his paper considers the group of cases in which fibrous changes in the lung are the direct sequel of a more or less acute pneumonia. Two illustrative cases were described in which this sequence of events was beyond doubt. The onset was well defined and acute, but the constitutional depression was less severe and later in its development than in the classical form of pneumonia. Pyrexia was moderate in degree and of irregular type. The sputum was not rusty, a characteristic of pneumonia; in one case it became putrid towards the close. In each instance a fatal termination was reached within four months from the commencement of the illness. In one case death was due to cardiac failure; in the other it depended on septic broncho-pneumonia and nephritis. *Post-mortem* examination disclosed a lobar consolidation in each instance, with cavities of varying size and character, and an absence of any tubercular lesion. Microscopically the induration was found to be due to organization of a fibrinous intra-alveolar exudation in the first case; in the second the connective-tissue growth was interstitial. The conclusion was drawn that these cases represented a special variety of pneumonia distinct from the classical sthenic type, and best described as indurative pneumonia.—*Brit. Med. Jour.*, March, 29, 1890.

Creed (J. M.) on Leprosy in its Relations to the European Population of Australia.—The author claims that leprosy is contagious, but only under circumstances (extremely favorable to its propagation) which lower the vital powers of the persons exposed to it; and that there is no real danger to people who live with good sanitary surroundings, have a fitting, wholesome diet, and are personally cleanly, however intimate their association with the leper is. The disease may be hereditary, but frequently skips generations, and becomes less severe as the descent becomes remote. Constitutional syphilis increases the liability to the disease. It is not incurable, though intractable, and cases improve under treatment, and there are cases of spontaneous cure.—*Australasian Med. Gaz.*, March, 1890.

Vanhersecke on the Heart in a Case of Diabetes.—There was considerable œdema of the cellular tissue of the organ, in front and behind. It also invaded the endocardium in the neighbor-

hood of the orifices. In some places the œdematous exudation was gelatiniform in character.

The case was peculiar from the fact that ordinary symptoms of diabetes were absent, while though four ounces of sugar were passed daily. There was general œdema implicating the limbs, peritoneum, pericardium, pleura, and cellular tissue of the heart. Although resembling a case of nephritis, there was never any albumen in the urine, and the kidneys were healthy.—*Bull. Méd. du Nord.*, March 28, 1890.

Vincent on the Presence of Elements Resembling Psorosperms in Flat-Celled Epitheliomata.—In numerous epitheliomata in the midst of epithelial collections or in their neighborhood, the author has found peculiar bodies very like psorosperms. They are encysted in the cell, driving the nucleus to the periphery. The sections should be treated by ammonia, and then colored by immersion in a concentrated solution of safranine for five minutes, and then decolorized by a one per cent. solution of acetic acid. This procedure gives the parasites a bright rose tint, which brings them out in strong contrast to the yellow or violet of the cell. No attempt has been yet made to cultivate them.—*Gaz. Hebd. de Sci. Méd. de Montpel.*, March 15, 1890.

THERAPEUTICS.

Randolph (R. L.) on the Use of Fluorescein as a Means of Diagnosing Lesions of the Cornea.—Fluorescein is a red powder soluble in water, and belongs to that class of substances which are found as products of coal-tar distillation. I employ a solution of ten grains of the powder to the ounce of water, to which is added fifteen grains of the bicarbonate of soda.

I have never known the solution to have an irritating effect, and I have used it in the most intense forms of corneal inflammation. The portions of the cornea stained retain the color from half an hour to several hours. The solution produces not the slightest impression upon the healthy cornea. I have always found that when positive defects in the corneal epithelium existed—in other words, where there was actual loss of substance,—the coloration was more apparent. So long, then, as it is possible to color any portion of the cornea, we may be certain that some lesion still exists. In excoriations of the cornea positive results were the rule. One case I remember particularly where the cornea had been scratched by a blow from a twig, and where the extent of the excoriation was scarcely visible to even oblique illumination. Every detail of the wound and every minute point, where the epithelium had been removed, were clearly brought out by a drop of the fluorescein solution. The other conditions, in which diagnosis is aided by this agent, are ulcers of the cornea and foreign bodies on the same. There must exist some solution of continuity of the superficial epithelial layer to render this agent of any diagnostic aid. Under these circumstances it brings to light lesions invisible to the closest scrutiny without its use. Microscopical examination reveals that the agent has no special affinity for definite histological elements of the living cornea, such as the nuclei of the cells.—*Johns Hopkins Hosp. Bull.*, April, 1890.

Belt (E. O.) on Hallucinations from Atropine Instillations in the Eye.—A man of about twenty-five years presented himself for treatment of a central corneal opacity of the left eye, which greatly obstructed vision. An iridectomy was performed on Friday afternoon. I instilled one drop of atropine solution (four grains to one ounce) in the eye three times daily. On the following Sunday, after the seventh instillation during a period of about forty-eight hours, he acted and talked strangely. On making my rounds that evening I found him somewhat excited. He gave foolish replies to questions, his face was flushed, pulse rapid, and the pupil of right eye was widely dilated. I discontinued the use of atropine, but did not deem an antidote necessary. About one o'clock that night, however, I was aroused by the nurse, who said she thought the man was crazy. Upon going to his room I found him dressed in overcoat, boots, and hat, and crying like a child. He said that he had just seen a man split his father's head open with a broad-axe. I told him he was mistaken, and induced him to retire. After one sixth grain of morphine, he quieted down and slept until morning. He was somewhat "flighty" during that day, but afterward was rational. Such effects are not uncommon when the atropine is instilled at intervals of an hour or two, but are extremely rare when it is used only three times during

the twenty-four hours.—*Med. News*, April 5, 1890.

Mays (T. J.) on the Hypodermatic Treatment of Asthma with Strychnine and Atropine.—Three cases of asthma were treated with strychnine alone, and three with the addition of atropine. I begin with one fiftieth of a grain of strychnine and one one-hundred-and-fiftieth of a grain of atropine daily, gradually increasing the former to one twentieth or one twenty-fifth of a grain and the latter to one one-hundredth of a grain. After a thorough impression is made on the disease, the drugs are administered every other day, and as the patient improves are gradually abandoned. While some cases get well under this treatment alone, necessity in others demands that the influence of these agents be fortified by efforts which seek to control the causes of the attack, as well as by measures which build up and fortify the general system.—*Boston Med. and Surg. Jour.*, April 3, 1890.

Boymond on Aristol.—The author, experimenting in skin diseases, thinks this new remedy will replace iodoform, iodol, and sozoiodol because of its harmlessness, its energetic action, and its freedom from odor.

It consists of a voluminous, amorphous, reddish-brown precipitate, which results from the mixture of a watery solution of iodine in iodide of potash with thymol dissolved in caustic soda.

It is insoluble in water or glycerine, slightly soluble in alcohol, easily soluble in ether. For use it is combined with oils or ointments, or sprinkled dry upon wounds or burns. It is not absorbed, and has no toxic properties. It is as efficacious as chrysarobin in psoriasis, and does not color the skin nor provoke conjunctivitis.—*La Prat. Méd.*, March 25, 1890.

Curgenven (J. B.) on Eucalyptus in Scarlet Fever.—The author employs a mixture which contains, beside eucalyptus oil, menthol, and several essential oils and camphors. He gives it internally in frequent doses of a few drops shaken up in water; he saturates the clothing, sheets, pillows, etc., and sponges the entire surface of the body twice a day with it, besides sprinkling the floor, furniture, walls, etc., till the air of the apartment is impregnated with the not unpleasant odor. He has not practised spraying of the throat, but says that in severe cases, and certainly in diphtheria, he would consider such a procedure advisable. The results he has invariably obtained were the immediate arrest of the eruption, which did not extend further, the speedy relief of angina, and subsidence of enlarged glands, rapid defervescence of the fever, the temperature falling from 104° or 105° to 100°, or even to normal, within a few hours, and the entire absence of albuminuria due to the elimination of such oils by the kidneys; in short, the immediate arrest and cure of the disease. Further, it is, he maintains, no less effective in aborting the disease and in protecting the most susceptible persons against infection, even though they remained exposed to it.—*Brit. Med. Jour.*, March 29, 1890.

Combemale and Francois (A.) on the Thereapeutic Value of Exalgine.—The authors cite eight cases in which they have employed exalgine. Five cases were acute articular rheumatism in all stages and forms of the malady; one was a sciatic neuritis, one hyperæsthesia, and one a neuralgia, probably syphilitic.

In seven cases pain was suppressed, or considerably diminished, for at least ten hours. Repeated doses were frequently required, showing the exalgine to be a true analgesia of medium duration.

Sweats are an invariable accompaniment to the analgesia. Diaphoresis is not, however, a strict contra-indiction to the use of the drug; where fever is the predominant symptom the authors still employ antipyrine and salicylate of soda; where pain predominates they use exalgine. They give about eight grains, in solution, an hour before bedtime.—*Bull. Méd. du Nord.*, March 28, 1890.

Acheson (G.) on Epileptiform Convulsion Produced by Exalgine.—L. T., a young lady aged eighteen, consulted me on the 25th of January last, during the prevalence of the influenza epidemic, suffering from the initial symptoms of a severe "cold," the most pronounced of which were pains in the head, back, and limbs, feverishness, and sense of oppression in the chest. She was anxious to get immediate relief, and, having a solution of exalgine with me, I gave her at once a dose of somewhat less than four grains. About two minutes after she had taken it she complained that she felt "very funny," and she repeated this expression once or twice. Within five minutes she had a well-marked

epileptiform convulsion, lasting about two minutes, during which the tongue was bitten, and there was complete loss of consciousness. Consciousness gradually returned in about twenty minutes, with nausea and vomiting. On coming to herself she said the pains were all gone, and beyond a stupid feeling for some hours, no bad effects seemed to have followed the fit.

I have used exalgine as an analgesic in single four-grain doses on several occasions, both before and since this case, and at no other time has it produced any but the most satisfactory results. The convulsion in this instance may perhaps be explained by the history of the patient. Her family history and her own temperament are highly neurotic; and about puberty she suffered from hystero-epileptic attacks, though for the last three or four years there had been no evidence of such a condition. At the time the drug was administered she was in a state of over-wrought nervous excitement, and resistance was at a minimum. Further, the stomach was empty, and the drug in alcoholic solution was completely absorbed almost at once. The nerve-centres, therefore, in a condition of unstable equilibrium, were overpowered and lost their balance.—*Canad. Pract.*, April, 1890.

Bardet on Hypnol.—This agent results from the reaction of chloral with antipyrin. It seems to possess the sedative and hypnotic properties of its components. Fifteen grains is the dose and in twenty-two cases the author has seen sleep follow its use. It is, moreover, useful in the insomnia from pain or cough. It does not taste badly like chloral, nor has it any more irritant action on the stomach than its two constituents.—*La Prat. Méd.* March 25, 1890.

Gordon (J.) on Sulphonal. — The summary of results detailed in this contribution are as follows:

1. The drug reduced the excitability of the reflex function of the spinal cord.
2. It diminished peripheral sensation.
3. Clinical observations showed that large doses slowed respiratory acts.
4. That it did not affect the pulse rate.
5. That it slowly destroyed the conductivity of motor nerves, and that subsequent washings with salt solution tended to restore it.
6. That saturated solutions slowly diminished irritability of muscle, but subsequent washings with salt solution tended to restore the irritability.
7. That small doses, 5 to 10 grains, increased excretion of urea.
8. That large doses diminished excretion of urea.
9. That under the influence of the drug the excretion of phosphates was diminished.
10. That it had no marked influence on the excretion of the fluid constituents of urine.
11. That in none of these experiments was any cutaneous eruption observed.
12. There was no flushing or perspiration markedly observed.
13. That its influence on temperature was negative.
14. That it occasionally caused vomiting, but there was no marked loss of appetite.
15. That diarrhœa was noticed occasionally.
16. That in good health an hypnotic effect was distinctly produced.
17. That in cases of insomnia it was reliable.
18. That the sleep which followed its administration was generally tranquil and refreshing.
19. That sometimes the patient woke with a feeling of confusion.
20. That inco-ordination of the upper extremities occurred occasionally.
21. That inco-ordination of the lower extremities occurred occasionally.
22. That a feeling of depression occasionally supervened.
23. That giddiness was observed.

Br. Med. Jour., March 29, 1890.

Wallace (D.) on Motor Paralysis after Hypodermic Injection of Ether, Illustrated by Two Cases.[1]—In both of these cases twenty minims of sulphuric ether were injected into the forearm of patients suffering from collapse; next day both cases suffered from paralysis of the muscles supplied by the interosseous nerve. In the first case the ether was injected subcutaneously; in the second, deeply; still both were followed by the same accident. The treatment adopted was first of all massage. This was continued for a week, but was followed by no good result. Blisters were next applied, but produced no effect.

[1] See case of ulnar neuritis caused by a hypodermic injection of ether, C. W Sharples, MEDICAL ANALECTIC, 1889, p. 488.

Galvanism was now begun, one month after the paralysis occurred, the muscles being still paralyzed and atrophied. Local improvement set in in about a week, and after three weeks of the application the hand and forearm had regained a considerable amount of power and strength. The treatment was still being applied, and the case still improving. The accident was probably due to the nerve being pierced, and to the action of ether on nerve tissue. The theory of its being due to bad ether could be dismissed in these cases. Dr. Wallace's conclusions were that deep injection of ether into the forearm was apt to cause the paralysis, and that hereafter he would inject it subcutaneously, that the prognosis was good, but recovery very slow, and that galvanism was better than faradism in effecting a cure. The accident was a very troublesome one, but fortunately of rare occurrence, and very few cases of it were found recorded.—*Med. Press*, April 9, 1890.

Lavaux on the Use of the Nitrate of Cocaine in the Treatment of Urinary Affections.—Led almost to abandon the use of the nitrate of silver because of its very painful local effects, the author tried to alleviate the pain by the previous employment of the hydrochlorate of cocaine without success. It then occurred to him to use the nitrate of cocaine. As there was no such salt in the market and as it kept poorly in solution, he resorted to an extempore preparation of the salt by dissolving gr. xv. of silver nitrate and gr. xxx. of hydrochlorate of cocaine each in ʒ iiss of distilled water and then mixing the two solutions. Filtration separates the chloride of silver and leaves a solution of the nitrate of cocaine fit for anæsthetic purposes, and which does not cause a precipitation of the silver salt locally applied. —*La Tribune Méd.*, March 13, 1890.

Moissan on the Anæsthetic Qualities of the Chlorides and Fluorides of Ethyl and Methyl.—In experiments on guinea-pigs the fluoride of ethyl does not anæsthetize, or this action passes unobserved, for the animals were always found in the apparatus dead. With the chloride of methyl anæsthesia is rapid and complete. Anæsthetization by the fluoride of methyl lacks the stage of agitation and the general loss of sensibility is complete. This change of action by substituting the elements of fluorine for chlorine is very interesting and has led to experiments looking to the substitution of fluoriform for chloroform.—*La Tribune Méd.*, March 6, 1890.

Effects of a Very Large Dose of Acetanilide.—A number of cases have been recorded showing that even moderate doses of antifebrin or acetanilide may be followed by toxic symptoms, but no case has until now been reported in which nearly an ounce of this drug had been taken. It has generally been supposed that the toxic properties of acetanilide are due to the aniline of which it is manufactured, and it was therefore to be expected that the symptoms occurring in the two cases would be very similar. Dr. Hartge, of Dorpat, who has recently had ample opportunities of observing a case in which a student who had caught cold had dosed himself with twenty-eight or twenty-nine grammes (one ounce) of acetanilide in addition to a considerable quantity of spirit, states that the symptoms only very partially corresponded with those mentioned by Dr. Dehio as due to poisoning by 154 grains of aniline, and which consisted in blue coloration of the skin and mucous membranes, profound coma lasting for several days, irregularity and quickening of the respiration, acceleration of the pulse, the smell of aniline in the breath; loss of power of motion, considerable disturbance of the sensory powers, followed by jaundice, with anæmia, albuminuria, and hæmoglobinuria. It is probable that this aniline was by no means chemically pure, but contained several other substances, especially toluidine, which is nearly always met with in the aniline used for commercial purposes, and in that employed by bacteriologists for staining tubercle bacilli. In Dr. Hartge's case, notwithstanding the enormous dose of acetanilide which had been taken, a quantity which requires five sixths of an ounce of aniline to make it, or more than twice as much as Dr. Dehio's patient took, there was no loss of consciousness, of motion, or of sensation; no albuminuria or hæmoglobinuria, and only the slightest trace of jaundice; the blood corpuscles, too, presented their normal appearance and character, there being no detritus or specks of pigment, though the color of the blood was changed to a dark blue, as in aniline poisoning; also the respiration was rendered rapid and irregular and the pulse accelerated. The patient complained greatly of inability to sleep, and the cardiac palpitation and dyspnœa produced a feeling as of impend-

ing death. No medical aid was sought for many hours after the drug had been taken. When Dr. Hartge saw the patient first, he was much struck by the marked blueness of the skin, which was general over the whole surface, but especially dark in the eyelids, the chin, and the temporal regions. There was no puffiness, as in severe cases of asthma, and the general appearance was quite different from that of cyanosis. Although there had been no vomiting, a glass of red wine was immediately brought up, and the stomach was soon afterwards thoroughly emptied, a quantity of bilious matter being evacuated. The treatment consisted in giving sulphate of soda draughts, together with coffee and brandy, also hypodermic injections of camphor in ether, and the application of cold compresses to the head. On the third day the patient was able to leave his bed, and the blue color had entirely vanished. In conclusion, Dr. Hartge, who was fortunate enough to obtain Professor Dragendorff's co-operation in the working out of the case, remarks that there is reason to believe that the acetanilide taken by the patient must have been a remarkably pure specimen.—*Lancet*, April 12, 1890.

Cambo (G.) on a Curious Case of Cantharidis Poisoning.—On June 14th, the writer was consulted by a young woman who complained of sharp pains over the bladder and along the urethral canal with dysuria. Only drop by drop could the urine be passed by means of a great effort. The husband of the woman and their young son of eight or nine soon developed the same symptoms. It transpired that they had eaten at the preceding meal a half-dozen small birds taken from the nest, scarcely able to fly. By chance the intestines and gizzards of these birds were found, and they were found full of food containing a great many greenish-yellow fragments, which proved to be pieces of the wing covers of the *Lytta vesicatoria*.

The patients had no gastro-intestinal disturbance, but only urinary symptoms which yielded to an emulsion of camphor, taken internally, and applications of belladonna ointment.—*From El. Siglo Medico* in *Le Courrier Méd.*, March 15, 1890.

Erysipelas as a Remedy for Diphtheria.—A Russian practitioner has recently published the results of some very original and bold experiments, which he has carried out on a method of treating diphtheria. His son had the misfortune to contract diphtheria in a very serious form, and his death appeared imminent. At this critical moment erysipelas declared itself, and, contrary to their expectations, instead of giving the prostrated patient his *coup de grâce*, the appearance of the erysipelatous eruption was followed in the course of a few hours by a marked and persistent improvement in the condition, and the patient shortly afterwards became convalescent. This observation impressed the father, and induced him to inoculate his next bad case of diphtheria with the virus of erysipelas. He did this, as he admits, with fear and trembling, but the result was so successful that he did not hesitate subsequently to resort to the plan on a comparatively large scale. In the course of a few months he inoculated no less than fourteen persons suffering from diphtheria with a cultivation of the microbe of erysipelas. Twelve of these were saved, and in the two fatal cases the inoculations had failed, so that the author professes to have derived as much confirmation and encouragement from these two cases as failures, as from the twelve successful cases. His last feat was on five out of six children belonging to the same family, all of whom had contracted diphtheria. All the inoculated infants escaped, the only fatal case being the one who was not treated in the same way. This is not one of those methods of treatment of which it may be said that if they do no good they can at any rate do no harm, and few medical men would hasten to have recourse to such heroic measures even on the authority of an unknown Russian practitioner. It should be noted that in all the cases the inoculation only gave rise to moderate symptoms, and in no case did the erysipelas give rise to any anxiety.—*Med. Press*, April 2, 1890.

Carter (H. R.) on Some Ill Effects of Disinfection with Sulphur.—Sulphur burnt in the presence of moisture may have the following undesirable effects:

1. It injures the colors of many woollen goods, being especially hard on greens and bright reds—a red flannel shirt, for instance, always comes out yellow, sometimes the color is not affected; the dark blues are generally absolutely uninjured, but not rarely turned a reddish brown. The same color of course may be from very different dyes and thus give different

results. The quality of the dye, as judged by the price of the fabric, is no criterion of how it will behave under sulphur. Clothes that have been worn are frequently discolored, when new ones, of the same nature, from the slop-chest are but little or not at all affected, doubtless protected by the oil used in weaving, which has not worn off.

I have seen but few colored goods, other than woollens, submitted to SO_2; in some instances they were bleached.

2. Articles containing starch, if not washed soon, are corroded—especially true of handkerchiefs, etc., and the cloth covers of books.

3. Blankets and hair pillows—which are utterly unsuited to the process—will retain for about a week a smell so disagreeable, in no sense like that of burning sulphur, that they are unpleasant to use. This persists in spite of airing and exposure to the sun, but is immediately removed by washing, or heating in an oven.

4. Flour in ordinary barrels will not "rise" with yeast for some days after exposure, and this effect penetrates for a considerable distance in the barrel.

Tea is ruined permanently, as is ground coffee. The same charge is made of its effect on smoking tobacco, but not using it I can only give the testimony of others.

It is hardly worth while to mention the tarnishing of metal-work—all save gold—or the consequent injury to watches, clocks, etc. Oil prevents this almost entirely. Apples and other fruit become scalded and worthless.

The gas in the above observations was obtained by burning as much sulphur as possible in the presence of abundant moisture in a compartment more or less close, kept closed from twenty-four to forty-eight and occasionally seventy-two hours. In general it was not possible to enter the compartment for some time—thirty minutes to an hour—after opening up. Where the apartment is more open less injury would be done and also less efficient disinfection. *Jour. Am. Med. Ass'n*, April 5, 1890.

Hardy on Tampons of Mercurial Ointment in Chronic Peri-Uterine Exudations.—According to the author, this treatment produces in most cases a speedy relief of pain, and, in consequence, an improvement of digestion and increase of strength. After about a month of treatment the courses are frequently augmented in quantity and duration. No cerebral or gastric trouble or salivation has been seen to follow treatment.—*Annals de la Soc. Méd.-chir. de Liége*, February, 1890.

OCCASIONAL REPORT ON SURGERY.

BY C. A. POWERS, M.D.

Bull (W. T.) on the Results of Treatment of Fracture of the Patella without Operation. — The author reports in detail twenty-two cases in which ultimate results had been carefully noted, and, from a study of these and an analysis of reported cases of recent fracture which had been treated by operative procedure, concludes that the results obtained by simple and appropriate confinement are so good as to render operative treatment, with its attendant danger to limb and life, unwarrantable. Dr. Bull advises apposition of the fragments by plaster strips and confinement of the extremity in gypsum splint for some six weeks. Great care must be taken, on removal of the splint, to guard against any sudden strain upon the knee-joint, and this care must be exercised for some months.—*Med. Record*, March, 1890.

Nickerson (N.) on Fracture of the Anterior Superior Spinous Process of the Ilium from Muscular Action.—A boy, aged seventeen, while running a foot-race of one hundred yards, was suddenly brought to a stop by feeling something give way in his hip, with a sensation of bones grating together. On examination there was found distinct crepitus with false mobility of the lesser fragment and much local tenderness. Simple confinement resulted in cure.—*Boston Med. and Surg. Jour.*, March 6, 1890.

McKee (A. B.) on Fracture of Clavicle from Muscular Violence.—The patient was a miner of forty-nine years. Three weeks before Dr. McKee saw him he, while lifting a heavy weight, felt something give way in the right clavicular region. The patient refrained from work for a few days, but sought no advice concerning his trouble. Upon returning to his labor, he noticed only slight pain, with a considerable weakness of that arm. Examination showed a large node or deposit of callus, the most prominent portion of which was about 2¼ inches from the

centre of the suprasternal notch. The sterno-clavicular articulation remained intact, and the proximal extremity of the clavicle could be traced outward, to the margin of the prominence, about three quarters of an inch. The protuberance was equal in size to a half-walnut, and the distal fragment of the clavicle was displaced slightly forward. Sliding of the fragment, with soft crepitation, was plainly marked, upon moving the arm, and was appreciable to the patient. By grasping the fragments of the bone with the fingers, movements at the point of separation could readily be produced. The man felt so little inconvenience from his injury that he desired no treatment. Three months afterward the condition of the part was found to be practically the same, save, perhaps, a slight diminution in size of the prominence. A pseudo-arthrosis was evidently present, and slight crepitation was still noticeable. Patient pursues his usual vocation, and notices no other inconvenience than diminished power in the right arm.—*Occidental Med. Times*, March, 1890.

Murdock (J. C.) on Passive Motion in Fractures near the Joints.—This author takes strong ground against the employment of passive motion in joint-fractures. He refers to a notable discussion in 1879 in the Société de Chirurgie, Paris; Verneuil, an advocate of complete immobilization, being one of the disputants. This discussion was carried on during several sessions. The weight of the testimony was in favor of immobility. Verneuil's argument was that the stiffness of a joint is the result of its inflammation and not of its immobility, and that immobility, being the best antiphlogistic under the circumstances, must have the effect of diminishing instead of increasing the stiffness. Any movement made in a joint which is contiguous to a fracture should be avoided until there is sufficient union between the broken fragments to prevent any displacement, and then only such movements as can be made without producing any pain. When pain, heat, or swelling follow efforts at passive motion, injury has been produced and anchylosis is more likely to follow.—*Fort Wayne Four. Med. Sci.*, Oct., 1889.

Pilcher (L. S.) on the Propriety of Passive Motion in the Treatment of Fractures in the Neighborhood of Joints.—"It has seemed to me that every time a motion was impressed upon a joint in the immediate neighborhood of which there was a fractured bone, we disturb the process of repair at the point of fracture, we increase local irritation, we excite excessive plastic exudation, we aggravate the amount of callus which is thrown out, we cause among the peri-articular tissues the collection or formation of plastic exudate which tends to cement them together and to limit their future functional activity; while, at the same time, we delay somewhat the perfection of the reparative process at the injured point itself. If I am correct, and the limited experience which I have had in the observation of these cases, had I time to marshal it, I think would sustain my position. If I am correct, the proper conclusion is to carefully avoid passive movements of these affected joints, or these joints the bones entering into the formation of which are injured near the joint, until full and complete repair of the lesion in those bones has been accomplished, until the inflammatory effusion necessarily following the injury has been absorbed, until the parts are in as nearly a normal condition as it is possible for them to be brought; and that even then violent passive motion should be carefully abstained from, and the parts left to the progressive physiological restoration of their function, a condition of affairs which all of us, I am sure, have been able to watch, as we have seen joints which were apparently nearly ankylosed when put to use gradually becoming more and more extensive in the excursions to which they might be subjected, until nearly complete restoration of the function of the parts had been accomplished. I am quite aware that this is in direct opposition to the teaching of some of those authorities upon the subject of these injuries which we look up to as of the greatest note."—*Brooklyn Med. Jour.*, Sept., 1889.

[All who have much to do with the treatment of fractures will coincide in the clearly expressed opinion of Dr. Pilcher. Passive motion, in most cases, is positively harmful.—C. A. P.]

Meyer (W.) on the Operative Treatment of Erysipelas.—The author strongly commends the treatment by multiple superficial scarifications introduced by Kraske, and modified by Riedel. The incisions should penetrate the chorion, and should surround the erysipelatous area.

They should be about two inches long and one fourth of an inch apart, and should cross one another at an angle of forty-five degrees. Thus the whole invaded region is encircled with a network of cuts, not unlike a rail fence. The incisions are made through sound tissue. Dressings of moist (1–1000) sublimate gauze should be applied, and changed two to three times daily. —*Med. Record*, March 15, 1890.

Wyeth (J. A.) on Removal of the Entire Clavicle, with Complete Reproduction of the Bone and Restoration of Function.—The patient, a boy 18 years of age, was admitted into Mount Sinai Hospital on October 3, 1889. Some weeks before, he had begun to have pain and had noticed a swelling in the region of the collar-bone. There was no history of injury. His general condition was fair. There was extensive necrosis of the clavicle, and on October 4th, under ether narcosis, the entire clavicle, being found dead, was removed. The periosteum was stripped carefully off, antiseptic dressings were applied, and the arm was kept in the position for fracture of the clavicle. The patient recovered rapidly, and on December 20th was discharged with a completely reproduced collar-bone, with new joints at the sternal and the scapular ends. The resultant shortening was unappreciable.—*N. Y. Med. Jour.*, March 8, 1890.

Thomson (John) on Congenital Absence of the Radius on Both Sides.—The girl was 16 years of age, healthy, and, with the exception of the forearms and hands, well formed. The condition of the forearms and hands was exactly the same on the two sides. The ulna was only 6½ inches in length, much curved, and thickened so that its lower end was 1½ inches in diameter. The radius was represented by a wedge-shaped fragment of bone, not an inch in length, which was closely attached to the upper aspect of the carpus. The hand was small, and without a trace of a thumb; it was articulated, or rather attached by fibrous tissue to the side of the ulna at a right angle, and moved round it. The chief point of interest in connection with the hand was the condition of the little finger, which was slightly larger, comparatively, than the other digits, and when at rest stood somewhat apart from the ring finger. The patient had acquired a considerable power of opposing the little to the ring finger, so that, in some sort, it took the place of a thumb, and she was thereby enabled to do a considerable amount of work with her apparently helpless hands. She could lift considerable weights, could button and unbutton her dress, could sew slowly, and could write wonderfully well. Dr. Thomson thought the case might interest the Society, not only because it was an example of a somewhat uncommon malformation, but especially as the amount of use which the girl made of the deformed limbs helped to throw light on the prognosis with regard to the possibility of future usefulness which one might give in such cases.—*Edin. Med. Jour.*, March, 1890.

Roughton (Edward) on Angiomata and Angiosarcomata of Bone.—The author thought that these blood-vessels were developed from the myeloid cells of red bone-marrow, and that the more embryonic they were the more malignant the tumor in which they were situated. In the innocent blood tumor of bone the vessels were more highly developed, but still too weak to contain blood. When the vessels attained sufficient maturity to admit of no extravasation, the tumor ceased to have the characters of a blood tumor, and was, in fact, a pure angioma. Such tumors, although more common in other parts, had been several times met with in bones. With regard to the treatment of these tumors, it was suggested that they should be incised, and if found to contain little or no solid matter, allowed to granulate up. If after incision the tumor continued to grow, free removal of the diseased part should be practised.—*Lancet*, Dec. 14, 1889.

Deaver (John B.) on Secondary Bone Implantation by a Modification of Senn's Method.—As this new aid to the rapid healing of cavities is under trial any contribution is welcome. Dr. Deaver relates a case in which he successfully closed a large cavity left after an operation for necrosis of the femur, and gives the following precautions, and rules for preparation of the bone-chips. The precautions for the operation are: first, that the granulations must be perfectly healthy; second, that the wound be thoroughly irrigated twice daily for several days previous to the operation with a solution of 1 : 2000 bichloride of mercury; third, that the iodoform should be sterilized; fourth, that the bone-chips should be aseptic; and last,

but the most important of all, complete and thorough asepsis.

The bone-chips should be prepared as follows: The bone to be preferred is the tibia or femur of a freshly killed bullock, which can be easily procured at an abattoir. It should be immediately wrapped in a wet aseptic towel, or several layers of wet aseptic gauze, to prevent infection while being carried.

Arriving at the office the bone is to be sawed into segments two inches long, the articular extremities being discarded. Place the segments in a fifteen per cent. solution of hydrochloric acid in distilled water, after having removed the periosteum and marrow. This solution should be changed every twenty-four hours, until the segments become decalcified, which requires from two to four weeks. When this process is completed the segments are to be washed in distilled water, then immersed in a dilute solution of caustic potash to remove the excess of acid. After the acid is neutralized, the segments are again immersed in distilled water for twenty-four hours, when they are taken out and the cancellous structure in the medullary canal removed. The segments are now to be cut into strips in the direction of the long axis of the bone, of one half to three quarters of an inch in width. They are then ready for the last step in the process of their preparation, that of slicing them into chips of one millimetre in thickness. The chips are now to be placed in a glass-stoppered bottle containing a solution of bichloride of mercury in alcohol 1 : 500 and kept there until used. At time of operation the necessary amount of chips is to be placed in a five-per-cent, solution of carbolic acid.

[The procedure, is at present on trial in the wards of the New York Hospital. It has not, as yet, been sufficiently successful to warrant endorsement.—C. A. P.]

Armstrong (S. T.) on Upward Dislocation of the Sternal End of the Clavicle.—A sailor, thirty-nine years of age, was thrown against a bulwark during a storm; he was unconscious for some time, and on regaining his senses felt a severe pain in his right shoulder and arm. When admitted to the hospital, a fracture of the right ulna was found. The sternal extremity of the right clavicle was dislocated upward, and rested on the upper margin of the manubrium sterni; by pressure it could be reduced, but it would gradually slip upward and forward again.

The condition of the patient was such that any attempt at fixation of the dislocated bone was precluded. He was kept on his back for two weeks.

The sternal end of the clavicle projected when the patient was discharged, but there seemed to have been a partial re-formation of the ligaments, and the range of mobility was slight. With constant use it is possible that the dislocation may be aggravated, but it is improbable that the use of the arm will be interfered with.—*Jour. Am. Med. Assoc.*, July 6, 1889.

Edwardes-Ker (G. C.) on Luxation of Sacro-Iliac Articulation.—The patient, a woman of 37 years, sought relief for an excruciating lumbar pain, which came on suddenly whenever she made sudden or violent effort. Examination revealed a decided "fore and aft" movement in the sacro-iliac articulation. This being accompanied by a severe and sickening pain. Relief followed support by a laced abdominal belt.—*Lancet*, Nov. 23, 1889.

Littlewood (H.) on Dislocation of the Metatarsus.—A woman of thirty-one years had fallen from a chair to the ground. On examination the left foot was found to be everted, the metatarsus forming a slight angle with the tarsus. There was much swelling on the dorsum of the foot; the extensor tendons were prominent; the hollow of the sole was less marked than on the opposite side. On manipulation of the dorsum, the articular surfaces of the bases of the four outer metatarsals could be distinctly made out above the level of the tarsus (about one third of an inch). The big toe was not dislocated from its cuneiform bone, but the internal cuneiform bone was dislocated upward from the navicular bone, forming a distinct prominence on the inner side of the dorsum of the foot. The measurement from the heel to the tip of the hallux was the same as on the opposite side; from the external malleolus to the tip of the fifth toe it was a third of an inch less. Under chloroform the dislocation was easily reduced by making traction, and at the same time pressing downward on the bases of the metatarsals. No crepitus was felt.—*Lancet*, March 2, 1889.

Morton (T. G.) on Unrecognized Dislocation of the Humerus; Section of the Neck of the Bone.—The patient was a man of twenty-four years, who was

admitted to the hospital with severe injuries of arm and forearm. The swelling of the arm and shoulder was so great that it was impossible to make any further diagnosis other than that of a very extensive injury of the soft parts about the shoulder and comminution of the humerus. The limb was elevated, and lead-water and laudanum applied; subsequently a dislocation of the head of the humerus was made out, but owing to the serious nature of the injuries of the arm and forearm no attempt was then made at reduction; some weeks later, when union had taken place, the head of the bone was found attached to the tissues. The arm was practically useless so far as shoulder motion was concerned. A vertical incision was made through the deltoid down to the head, and the bone so firmly attached in the abnormal position that it was not possible, without the greatest risk, to attempt to dislodge it. He then carried a chain-saw around the bone at the anatomical neck, and sawed the shaft obliquely from below upward, and then readily placed the divided end in the glenoid cavity. A rubber drain was placed in the wound, which was closed with gut sutures. The wound united promptly; a slight sinus remains. Massage and electricity have done much for the feeble muscles, now much improved, and a fair amount of motion in the shoulder has resulted; this is constantly improving. The patient has been since the operation quite free from pain, and bids fair to have a very useful arm. Dr. Morton has been unable to note that any trouble has arisen from the presence of the head of the bone in its unnatural position.—*Med. News*, Aug. 3, 1889.

Wight (J. S.) on the Operative Treatment of Chronic Housemaid's Knee.—The author describes a number of cases which he has cured by free incision with erosion of the sac wall. He sews the wound with layers of buried sutures, applies firm compression, and obtains primary union throughout.—*Brooklyn Med. Jour.*, March, 1890.

Abbe (R.) on Tubercular Teno-Synovitis.—The author relates the case of a woman on whom he had excised the sheath of the flexors of the thumb and index and little fingers because of the growth of melon-seed bodies, now recognized to be the result of tubercular inflammation. The case was interesting in connection with the question of secondary operations to free divided tendons. Notwithstanding complete removal of the sheath of the tendons in this and other cases, freedom and power of motion had afterward been complete. The wound must be kept antiseptic, and primary union take place. Only voluntary motion was resorted to; this was begun on the sixth day.—*Med. Record*, Nov. 2, 1889.

Symonds (C. J.) on the Use of Large Grafts from Amputated Limbs.—The author had used these grafts in four cases, each being attended with success. He says that some special care is required. The speediest plan is to shave off the skin with a razor, taking of course the rete Malpighii only. The grafts must be kept in lint wrung out of weak carbolic during the transit from the amputated limb to the ward, unless of course the patient be near to this. An interval of fifteen to twenty minutes between the amputation and the application of the grafts did not interfere with success. It is difficult to keep such large grafts in position; the corners must be held down while the dressing is laid over it, and pressure with the hand steadily maintained until the bandage is applied. If the skin curl up or wrinkle, pus gets beneath and failure will result. The plan offers a rapid method of closing large wounds.—*British Med. Jour.*, Dec. 14, 1889.

Keller (Otto E.) on Actinomycosis of Brain; Trephining.—There being but two cases of this rare disease on record, the following possesses unusual interest:

A woman of forty years suffered with actinomycotic abscesses of the ribs and cartilages. These were opened, scraped, and healed. Two years afterward she developed a gradually increasing weakness of the left arm, this giving place to convulsions, which took the typical course of cortical epilepsy, the paresis extending from the left arm to the left lower extremity and to the left side of the face. Operative procedure was advised, but refused, and was only undertaken when the patient became moribund. The brain was opened over the left motor area, and two ounces of thin, green pus removed, the fluid containing great quantities of actinomyces grains.

The patient recovered, but at the end of a year the symptoms returned, when the brain was again opened and a further purulent collection evacuated.

She died a few days thereafter. Autopsy

revealed a large mass of newly formed tissue over the surface of the right frontal and parietal convolutions, and beneath this an unopened encapsuled abscess the size of a nutmeg.—*Brit. Med. Jour.*, March 29, 1890.

Fowler (George R.) on a Case of Gunshot Wound of the Head; Bullet Located by Means of the Telephonic Probe; Operation; Recovery.—A boy of five years suffered a gunshot wound of the face by the accidental discharge of a .32 revolver. The wound was probed, but the only information obtained by this was the fact that the anterior wall of the antrum of Highmore had been perforated by the ball. The probe passed directly backward and was arrested at the depth of an inch, but whether by bone or the bullet could not be determined. The telephonic probe was then brought into requisition in the following simple manner, as suggested by Dr. Girdner, of New York: An ordinary metallic sound-gauge was attached to about two feet of ordinary insulated copper wire, and the other extremity of this latter was attached to one of the binding posts of a telephone (receiver); from the other binding-post of this instrument a similar piece of wire passed to the eye of a silver pocket-case probe. The sound-gauge was held firmly pressed against the surface of the cheek of the child, and, with the telephone applied to the ear, the probe was again passed down through the wound, and the characteristic rasping, clicking sound heard in the telephone, which announced the contact of the probe with some metallic substance in the tissues. Following the course of the probe, the ball was extracted without difficulty from the spheno-maxillary fossa by means of a Péan forceps.—*N. Y. Med. Jour.*, Aug. 24, 1889.

Lane (Arbuthnot) on Trephining for Old Hemiplegia Accompanied by Severe Headache.—The patient was a male, aged twenty-nine, admitted into Guy's Hospital, September, 1888. Fourteen years previously he had twice fallen on his head. After each fall he was insensible, and he was admitted into Guy's after the second fall for left hemiplegia and violent pains in the head. He stayed in eight weeks, but had no fits during his stay, and he went out in the same condition as on admission. After he left the hospital he had frequent fits, chiefly on the left side of the body, but somewhat on the right. The last fit was about March, 1887. During the whole of the fourteen years he had suffered from severe headaches. On his admission, September, 1888, his general health seemed good; examination of his skull did not reveal any trace of his former injuries. He had left hemiplegia. The left arm was flexed and pronated, the muscles were wasted. The leg was affected to a less degree. The left side of the face was slightly contracted. The only other important symptom was the severe headache, which the patient said made his life unendurable. It was thought probable that the falls on the head had caused in some way partial destruction of the cortical motor area on the right side, and it seemed extremely probable that there was still some chronic inflammatory thickening of the parts in the neighborhood, because for thirteen years the patient had suffered from epileptiform seizures, and had always complained of severe headache. Accordingly Mr. Lane trephined over the middle of the fissure of Rolando on the right side. The bone in this region was three fourths of an inch thick. This bone was present over the whole of the fissure of Rolando; it gradually shelved into normal bone on either side; the dura mater was thickened, and the ascending frontal and ascending parietal convolutions were much wasted. The thickened bone and dura mater were removed. The wound healed perfectly, and except for two attacks consisting of a fit and some headache, the patient did uninterruptedly well. These two attacks were probably due to some inflammatory exudation following the operation. Otherwise the patient has had absolutely no headache since the operation, which now took place seventeen months ago. He has also gained considerable power in walking.—*Med. Press*, Feb. 19, 1890.

Evans (Q. H.) on a Case of Puerperal Peritonitis Treated Successfully by Laparotomy and Abdominal Irrigation.—The patient was a woman thirty-four years of age, who had a miscarriage at three months, this followed by peritonitis. When seen the pulse was 157, respiration 34, temperature sub-normal, and the patient in collapse; abdomen greatly distended. Abdominal section, thorough irrigation with warm water and well established drainage resulted in cure.—*Med. Rec.*, April 14, 1890.

Marani on Abdominal Drainage-Tube Passed per Rectum.—The author describes in the *Siglo Medico* a case where a rubber drainage-tube was passed into the abdominal wound after the removal of a large dermoid cyst which adhered to the parietes, the omentum, and the liver. The patient was forty-six years old. The wound healed within a week, but the tube had been allowed to slip into the abdominal cavity. The patient complained of pain, referred to the left anterior superior iliac spine. A week after the healing of the wound the tube was passed during defecation. It had probably caused inflammation of the adjacent large intestine, and passed through the softened walls of the gut.—*Brit. Med. Jour.*, July 13, 1889.

Lutz on Properitoneal Hernia.—The following propositions are set forth:

1. The hernia is usually congenital.
2. The testicle is atrophic; its descent incomplete.
3. There is either a swelling over Poupart's ligament, or a sense of increased resistance or tenderness on pressure.
4. There is atrophy of the abdominal walls at the seat of swelling.
5. After apparently successful taxis the abdominal pain becomes more intense.
6. After herniotomy the loops of gut lying in the scrotum cannot be reduced.
7. If replaced, the loops of intestine again descend, or lie fixed in close proximity to the internal abdominal ring.
8. On dividing the properitoneal sac there is a discharge of hernial serum.—Abstract in *Am. Jour. Med. Sci.*, July, 1889.

Treves (Frederick) on Hernia into the Foramen of Winslow.—The author makes a very valuable contribution to our knowledge of this form of internal hernia by an excellent description of the clinical history, operation, and post-mortem discoveries in a case which came under his care. The clinical history indicated a complete intestinal obstruction involving the colon not far from its commencement, and some peritonitis in the epigastric region. An exploratory laparotomy was performed, hernia through the foramen of Winslow was diagnosticated, and two or three feet of small intestine was reduced, but another coil could not be reduced, as it was impossible to enlarge the opening through which the bowel had passed. On autopsy, it was found that the cæcum, the descending colon, and part of the transverse colon had passed through the foramen of Winslow and had become strangulated. The cæcum lay at the extreme left of the abdominal cavity, had forced its way through the anterior layer of the gastro-hepatic omentum, so that the vermiform appendix was lying on the anterior aspect of the lesser curvature of the stomach close to the œsophagus. The strangulated colon was gangrenous in two places and had ruptured. Outside or beyond the foramen of Winslow the colon bent very sharply to the left, and was again sharply bent at the splenic flexure. A few inches of the ileum were found in the hernial cavity, and lay at the seat of stricture behind the colon. Reduction of the strangulated colon could not be accomplished until the hepatic artery, portal vein, and bile-duct had been divided. The foramen of Winslow admitted four fingers. It was evident that the cæcum was undescended and had led the way through the formen. All the other viscera were normal. Only four other cases of this condition appear to be on record.—M. L. Foster in the *N. Y. Med. Jour.*, Aug. 10, 1889.

Heener (G. H.) on Lumbar Hernia.—The patient was a man of 68 years. When seen, the tumor was as large as a child's head. It occupied the left lumbar region between the crest of the ilium and the last rib. Symptoms of strangulation had been present for two days.

A slanting incision was made from the crest towards the ribs. After the skin and subcutaneous tissues, a thin muscular layer—the anterior portion of the latissimus dorsi—was cut through. Immediately underneath was the sac. This when laid open was found to contain anteriorly a coil of small intestine, inflamed and granular; next another coil of small intestine, quite gangrenous; and most posteriorly the sigmoid flexure which had become twisted on itself. The sac communicated with the general peritoneal cavity by a slit-like aperture, and across the neck were stretched two tense cords, which were the agents in producing strangulation. When these cords were divided it was easy, after separating some adhesions, to return the sigmoid flexure and the most anterior portion of the small intestine into the peritoneal cavity. The gangrenous coil was resected to the extent of thirteen inches, the cut ends of the bowel being reunited by Lembert's

stitches of fine silk ; and this portion of the intestine also was replaced. The sac was then stripped out of its bed, and cut away at the neck. The margins of the peritoneal opening were united by a continuous suture of strong catgut.

The patient rallied fairly well, but sank somewhat suddenly twenty-four hours after the operation.

So far as the disposition of parts could be ascertained during the operation, it seemed to be as follows : The hernial protrusion had taken place in front of the quadratus lumborum, and had expanded but not pushed through the anterior portion of the latissimus dorsi. When the sac was separated from its bed it seemed to have lain between this muscular layer and the aponeurosis of the transversalis. The rupture did not appear to have protruded through the triangle of Petit.—*Brit. Med. Jour.*, July 13, 1889.

Hutchinson (J., Jr.,) on Lumbar Hernia.—A specimen of this rarely observed condition was obtained from an elderly and rather emaciated man, who died (from other causes) in the London Hospital ; the hernia was about the size of one's fist, was situated in the left lumbar region lying over Petit's triangle, and extending nearly from the last rib to the iliac crest, and it had existed for some years. It could be made to markedly diminish on pressure, was resonant to percussion, and had an impulse when the patient coughed. Gurgling could be detected when reduction was made, the swelling returning when the pressure was taken off. It caused the patient no pain and hardly any inconvenience. Hutchinson was inclined to think that the hernia protruded through the orthodox triangle, but found, on dissection, that this was not the case, as the aperture, which would admit two fingers and was circular in shape, was really situated above and to the inner side of the triangle. The protrusion was just outside the quadratus lumborum, through the transversalis aponeurosis and the latissimus dorsi, where the latter arises from the strong fascia covering the erector spinæ. Another interesting feature at the post-mortem examination was the absence of any peritoneal sac. The looseness of the attachments of the peritoneum in this region is well known, and is taken advantage of in certain operations, such as removing the kidney through a lateral incision. It was quite easy to make the peritoneum, by gentle pressure, protrude into the centre of the hernial tumor, and, as it was certain that it had habitually during life contained intestine, it is obvious that every time the latter was reduced the peritoneal sac must have returned with it into the abdominal cavity. Whether this feature has been present in other cases of lumbar hernia it is impossible to decide, but it is one rarely met with in connection with the more common varieties of rupture. —*Brit. Med. Jour.*, July 13, 1889.

Stierlin (R.) on Indications for the Various Operative Procedures in New Growths of the Rectum.—1. Cancroid of anal portion : Excision of the diseased tissues, and suture of the healthy mucous membrane.

2. Carcinoma extending circularly upward from the anus but easily definable. Lisfranc's method of amputation of rectum, if necessary, with posterior incision of the sphincter.

3. For neoplasms beginning considerably above the arms and extending circularly upwards, whether the upper limit can be felt or not, Kraske's operation is indicated. The sphincter is saved and longitudinal incision of the posterior rectal wall is avoided.

4. For very high-seated carcinoma the sacral method is the only one possible.

5. Simon's forcible dilatation will usually make limited tumors of the rectal wall accessible, if they are near the anus. When higher up in the posterior wall, Kraske's operation is in place.

In case of high-seated nodules in the anterior wall, a total resection of the gut will be best, or the sacral method must be discarded and the sphincter and perineum divided anteriorly from the anus according to Dieffenbach's method.—Abstract in *Annals of Surgery*, March, 1890.

Conant (W. M.) on the Anatomy of the Breast and Axilla in the Operation for Cancer.—Dr. Conant renders a service in again calling attention to Macalister's description of the axillary lymphatics which lie along the lower edge of the great pectoral, some close to the humerus, receiving the cutaneous brachial lymphatics ; some close to the thoracic wall ; others lie behind the great pectoral, receiving the lymphatics of the areola and nipple ; others overlie the costo-coracoid membrane close to the cephalic vein, receiving the lymphatics from the shoulder ; and some rest on the

axillary vein, receiving the deep brachial lymphatics.

He advises that the mammary incision should reach the axilla by passing two inches above the border of the pectoralis major, should extend over the swell made by the coraco-brachialis, and down the arm for about two inches. Dr. Conant says: "It will be seen at a glance that the lower end of this incision is the most dependent portion of the wound, and if one fears disturbance from oozing, the lower end of this wound need not be closed. . . . Neither deep sutures nor drainage-tubes are needed." We must confess [ED.] that we cannot agree with the above. If the axilla be properly cleared of its glands and fat, the resulting cavity can be well drained, if it is to be drained at all, only through a counter-opening. And we think that most surgeons feel that these wounds pursue a better course when they are given forty-eight hours of thorough drainage. The author very properly calls attention to the necessity for the complete removal of the fat, together with the glands and fascia over the pectorals and the serratus.—*Boston Med. and Surg. Jour.*, April 10, 1890.

Irish (J. C) on a Case of Abdominal Nephrectomy for Pyonephrosis.—The patient was a woman of 59 years, who suffered from a tumor which extended from the pelvis to the thoracic walls, completely filling the left half of the abdominal cavity. Examination *per vaginam* revealed nothing. The tumor was removed through a long median incision, and was found to contain seven quarts of pus. It was probably due to obstruction of the ureter by a calculus. The patient went on through an uneventful convalescence to a complete recovery.—*Boston Med. and Surg. Jour.*, Dec. 5, 1889.

Will (Ogilvie) on Amputation of Nose.—The patient was a man of fifty-two years, whose nose was the seat of carcinoma. When admitted to hospital, the whole nose to within three quarters of an inch of the nostril was swollen, hard, and livid, with a uniformly smooth surface, except where ulcerated, and with a sharply defined border. About the centre of the tumor there was a deep ulcer covered with bright-red granulations which bled freely. The skin was not movable over the growth, and was much thinned. The alæ of the nose were much broadened, and there was some bloody discharge from the nostrils. A slice of the tumor was removed and examined microscopically, when the diagnosis (of carcinoma) was confirmed. The operation consisted in plugging the nares, and removing the nose by a circular sweep with a scalpel. Some projecting bony parts were removed by means of a bone forceps, the soft parts were scraped with a Volkmann's spoon, and the resulting cavity was plugged with boracic lint. The subsequent progress was eminently satisfactory, the wound granulating speedily, and the resulting deformity was not nearly so marked as might have been anticipated.—*Brit. Med. Jour.*, Dec. 14, 1889.

Brun on Tuffier's Operation for Renal Fistula.—Dr. Brun believes that Tuffier's operation (extirpation of the fistulous tract with fixation of the kidney) is indicated only in those cases in which the ureter is fully patent, and in which the kidney and its pelvis are free from diffuse suppuration; while renal fistulæ, accompanied by suppuration in the kidney and by occlusion of the ureter, should be treated by nephrectomy, provided always that the opposite kidney is in good conditon.—*Gaz. des Hôpitaux*, Jan. 11, 1890.

Smith (W.) on Extra-Pleural Abscess Simulating Empyæma.—The patient, a man, aged thirty years, consulted Dr. Smith on October 20, 1888, for a severe pain in the right side, attended with pyrexia and general ill-health. The pain had suddenly set in six weeks previously. The signs seemed to indicate a right pleural effusion, with tenderness along the eighth and ninth ribs. Pus was detected by hypodermic puncture, and when the abscess was opened about a pint of fetid sanious pus escaped. The rib was found necrosed. Hectic fever supervened, and the patient sank at the end of three months. The post-mortem examination disclosed an enormous cavity in the wall of the thorax, fragments of several necrosed ribs from the seventh rib downward projecting externally. Right lung partially adherent; no fluid in either pleural sac. Heart and pericardium healthy. The abscess had further destroyed the right half of the diaphragm.—*Lancet*, Feb. 1, 1890.

Sibthorpe on Radical Cure of Hydrocele of Tunica Vaginalis Testis.—Twenty-six operations for paracentesis of hydrocele are recorded. In fourteen of these a radical cure was attempted, undiluted tincture of iodine being injected in

ten cases, and pure carbolic acid in four. As far as these small numbers go they show that there is not much to choose between the two methods; both appear equally efficacious in certain cases, and both are generally followed by some local and constitutional disturbance. The carbolic acid, however, appears to be followed by less pain than the iodine, though, with it, pain is by no means absent, as some surgeons would have us to believe.

Of the fourteen cases a radical cure was obtained in nine, a partial cure in three, while two were lost sight of.

The author cites the paper of McArdle (*Dublin Jour. Med. Sci.*, Sept., 1887), who gives the following relative dates of healing after the different methods:

Injection.	*Incision.*	*Excision.*
Billroth, 9th day	Volkmann, 8th to 10th day	Julliard, 10th day
Stoltz, 9th day	Küster, 14th day	Bergmann, 11th to 12th day
Weiss, 8th—9th day	Lister, 17th day	McArdle, 7th—12th day
	McArdle, 12th to 14th day	

The chances of recurrence are much less after entire incision, partial resection, or complete resection, than after injection. Mr. McArdle quotes 315 cases of injection by different surgeons in which the disease recurred in 13 per cent.; 245 cases of incision in which it recurred in 2.4 per cent.; 53 cases of partial resection in which it recurred in 1.9 per cent.; and 22 cases of complete resection in which the disease did not recur. He only recommends these methods for cases in which the trial of injection has been made and has failed.—*Brit. Med. Jour.*, Feb. 23, 1889.

REPORT ON ORTHOPÆDIC SURGERY.

BY JOHN RIDLON, M.D.

Browne (L.) on Spinal Injury.—Two cases are reported:

CASE 1.—Fracture-dislocation of the spine from indirect violence. In July, 1888, a man received a fracture dislocation of the spine between the seventh and eighth vertebræ by a forcible bending forward of his body. When seen, three days after the accident, there was displacement at the seat of injury and complete paralysis below. He was moved on a mattress to the hospital, and was suspended by his head and arms. The displacement was reduced with considerable difficulty, and a strong Sayre's jacket was put on. He was able to move his limbs in a fortnight, and by carefully washing out the bladder with boracic lotion the cystitis which existed was overcome in three weeks. He stayed in bed 104 days, and wore his jacket for three months more. He made a complete recovery, and has now resumed work as a collier.

CASE 2.—Fracture of spine from direct violence. In March, 1889, through the fall of a heavy iron girder upon a man's back he sustained a comminuted fracture of the spine with displacement at the eighth dorsal vertebra; three separate pieces of bone could be felt. He was seen a few minutes after the accident, removed to the hospital in an ambulance, suspended and put up immediately in a strong Sayre's jacket. No paralysis followed, and the man made a perfectly easy recovery, remaining in bed 118 days. His jacket was then removed and he was allowed to leave the hospital. He has remained well since.—*Birmingham Med. Rev.*, January, 1890.

Adams (W.) on the Successful Treatment of Cases of Congenital Displacement of the Hip-Joint by Complete Recumbency with Extension for Two Years.—Two of the six cases were double, that is, both hip-joints affected, and four single; in three of the latter the right hip-joint was affected, and in one the left hip-joint. In two of the cases, both examples of single displacement occurring in girls of about two years of age at the commencement of treatment, recumbency with extension has been carried out to the full period of two years in one, and two years and seven months in the other case; and they have been now some months walking about with a steel support on the affected limb.

At the present time I am enabled to report that the result of this treatment appears to be extremely satisfactory, and equally so in both cases. When these children are examined undressed on the table there is no apparent inequality in the length of the legs. Sometimes, by careful measurement, the affected limb seems to be an eighth, or from that to a quarter, of an inch shorter than the other, but we cannot always make as much. The iliofemoral triangle of the affected limb corresponds pretty closely with that on the healthy side, so that the head of the femur is now retained very nearly in its natural situation, and there is no disposition to

any spontaneous alteration. Nor is there any tendency to displacement upwards when gentle manipulation is tried by fixing the pelvis, and testing by a little movement directed upwards from the thigh. Of course this has only been tried gently, but the head of the femur seems to be fairly maintained in its improved position; and the contrast, as compared with the condition of parts before the commencement of treatment, is very great. All the movements of the joints are free, and the muscular nutrition has been well maintained.

The general health has not been in the least interfered with, and, indeed, in both instances, the parents consider that the children have improved in health. During the whole period of recumbency these children have been drawn out in a spinal carriage in the open air, lying down on the movable plane forming part of the extension couch, the extension acting all the time. The extension couch I have also used with great advantage in two cases of hip-joint disease.

At the present time we can only hope that the improvement gained by the treatment will be permanently maintained, but at least another six months or a year will be required to test this, after the children have left off the steel supports they are now wearing.—*Brit. Med. Jour.*, Feb. 22, 1890.

Smith (N.) on Bone Drilling in the Neighborhood of Inflamed Joints, and Elsewhere.—Three cases are reported in detail, in all of which the pain was almost immediately relieved. The writer sums up as follows: "Thus, by means of a very safe operation, an inflammatory process may be cut short, and a joint or bone saved from destruction. The value of this operation is very apparent in cases of inflammation of a joint, the acute symptoms being rapidly relieved, and the vexed question as to excision thereby possibly set at rest.—*Brit. Med. Jour.*, Feb. 23, 1890.

Taylor (H. L.) on the Treatment of Pes Equino-varus by Continuous Leverage.—The splint consists, in its simplest form, of a steel shank with guarded leg- and ankle-bands pivoted to a foot-piece of thin steel. The foot-piece has a sole-plate, and a side-plate fitted to the inside of the foot; there is a screw stop at the ankle-joint to flex the ankle, and there are straps across the instep which are guarded by a small steel bar. The shank is not usually pivoted directly to the foot-plate, but to a steel H-piece, which makes an offset from the ankle. The shank of this instrument is easily bent by the hand or by wrenches, according to the requirements of the case.

A three-tailed adhesive plaster is applied to the leg, a piece of webbing attached to the plaster was buckled to the heel of the apparatus. This keeps the heel from leaving the sole-plate when force was applied, and greatly increased precision.

After applying the three-tailed plaster to the inner side of the leg in the manner shown, the foot-piece of the apparatus, the shank having been properly shaped, is securely strapped to the foot, and the plaster webbing buckled to the heel of the splint; using the shank of the instrument now as a lever, the foot is thrown out and the leg-plate of the apparatus is strapped in place. All straps are so placed and guarded that there is no circular constriction of the limb, even after continuous use. The apparatus is, of course, properly padded, and is removed at least twice a day at first, to bathe the foot and make necessary modifications. The shank of the splint is gradually bent, forcing the foot over toward the valgus position. As the forward part of the foot swings outward, the original curve of the leg and foot becomes divided into two curves by the displaced heel; the upper formed by the heel with the tibia, the lower by the heel with the metatarsus. These are in turn directly attacked by our apparatus, thus pushing the foot out and over in the same manner as in the original curve, the inner side of the os calcis being added to the ball of the great toe and inner aspect of the upper end of the tibia as a fixed point of mechanical action, the convexity of the upper curve being drawn to the splint by a strap just above the ankle, that of the lower one by a strap over the cuboid and medio-tarsal region.

With this leverage and padding over the inside of the heel, if necessary to increase its force, the os calcis and heel swing over into place. The position of the os calcis is the key to the situation, and it is not able to resist this direct attack. In fact, it is necessary to be somewhat cautious not to force it too far over, and leave the patient with a permanent valgus.

When the os calcis has been brought into proper position, and the deformity has been

changed to an equino-valgus, the ankle is flexed by turning the set screw at the ankle-joint, the heel being prevented from rising by the plaster. During the few weeks that all this is going on it is important that the patient should not put his weight on his foot, as this throws much unnecessary strain on the plaster. When he can place the sole flat on the floor, walking in the splint will assist rather than hinder.

The apparatus must be worn day and night throughout the treatment, so that the foot may never return to the deformed position, and the contracted tissues may always be on the stretch. This moderate continuous stretching is irresistible, and is easily borne by the patient. During the prolonged after-treatment the patient is seen only occasionally, and goes about quite independently in his brace, which is completely concealed by his shoe and stocking. When the tissues of the foot are remoulded and stable in their corrected position, all treatment may be discontinued, though it is sometimes better to have the splint worn at night for a time.

Dr. Taylor emphasizes as important practical points :

1. The preservation of the heel-cord as an aid in unfolding the foot.

2. Exact prehension of the foot by means of an apparatus not attached to the shoe, and by plaster applied to the leg.

3. The application of leverage to the inner side of the foot and leg.

4. The reduction, first of the varus deformity, afterward of the equinus.

5. Thorough after-treatment. — *Medical Record*, March 8, 1890.

Barwell (R.) on the Treatment of Lateral Curvature of the Spine by Rachilysis.—He said that many different causes might set up the initial phase of lateral curvature ; it was a position in many instances forced on the spine by causes situated elsewhere, either in the body or altogether external, but throughout the first stage it remained, as far as the spine was concerned, a posture without morbid anatomy. But when this posture had continued a certain time the intervertebral discs retained the wedge shape which the sideways bend forced upon them, becoming persistently thinner on the side of the concavity. The anterior and posterior common ligaments, whose attachments on the side of convexity separated more or less widely, and on that of the concavity approximated, changed as all white fibrous tissues did under like circumstances : where constantly excessively stretched, they atrophied and became thin ; where continually lax, they thickened and shortened. Therefore the margin of those two ligaments which lay next the convexity of the curve became atrophied, lengthened, and membranous ; while that edge which lay in the concavity became strong, thick, and shortened. Also these ligaments after a certain time shifted their position, partly apparently by a process of gliding, and partly by actual addition of fibre along the edge subtending the concavity of the curve. For verification of these statements Mr. Barwell referred to a post-mortem examination made by himself in 1882, and to others made under more favorable circumstances by Nicoladoni. Eulenberg, and other morbid anatomists. The effect of these ligamentous changes was to bend the spine into the laterally curved form, as the knee or other joint was often tied into a flexed position by ligamentous contraction, and as in the case of joints restoration of rectitude was greatly impeded or altogether prevented, unless forcible means were used to stretch those shortened ligaments. Such application of power to the spine lying next to large cavities and important organs had met with difficulties hitherto insuperable, but which the author had overcome in the following manner. At the sides of the room he fitted an arrangement of rings and hooks from which the force worked. One padded band with loop attached was placed on the apex of the lumbar curve. The patient was inclined over against the restraint of the band until that curve was annulled or reversed, and the trunk was held in that position by a lanyard under the left axilla. Another belt with the loop in the contrary direction was placed on the apex of the dorsal curve. A system of pulleys was hitched to the loop, a wooden strut being placed between the laps of each band so as to prevent constriction. Mr. Barwell showed the action of his appliance on two boys from the Cripples' Home in Kensington, pointing out how their backs became straighter, and that the process was quite painless. Some of the Fellows measured their spines before and during the use of the power, and found in one case an increase of length of three quarters of an inch, in the other of one inch and three quarters—a result which showed that the

spines were thereby straightened and the contracted ligaments stretched. Cases were added of very rapid amelioration, and in one still under treatment almost complete rectitude was produced in about thirteen months.—*London Lancet*, March 15, 1890.

Brackett (E. G.) an Experimental Study of Distraction of the Hip-Joint.—Careful experiments were made on the cadavers of numerous adults and children to show the change in length and in width with the limb at different angles, and acted upon by different weights.

From the experiments and observations the following conclusions are drawn: The anatomy of the joint in small children does not offer any obstacle to a separation of these two surfaces in nearly the direction of the line of the leg, but in older children when the structure of the joint is beginning to assume the characteristics of the adult, some opposition undoubtedly is encountered. The ligaments offer a resistance which is yielding to a greater or less extent, particularly so in the older children where there is more bony opposition and their fibres run in a direction oblique to that of the separation.

Experiments show that distraction is an evident anatomical possibility. The muscles allow a motion in this direction within the limits of any possible distraction without being stimulated to a contraction by such change. When, however, the muscles are already in a state of spasm, they are reduced to a condition of quiet, and when in this state exert no active resistance to this slight separation of the joint surfaces. The manner of reducing this spasm is purely physiological. Their increased activity is due either to an excess of stimulus or to their increased irritability to ordinary stimulation. By this continual traction, which is simply a means of producing muscular exhaustion, the ability to respond to the stimulus is overcome, or so much diminished that spasmodic contraction does not oppose an active counter force to the traction. Therefore, if on anatomical and physiological grounds this separation is a possible fact, it should be a clinical reality.

The claim is not made that whenever continual traction is used, distraction occurs; probably not in cases of old disease where there are extensive bone changes or when there exists contractions and adhesions which have resulted from inflammatory process; nor that it does usually occur when used against contracted structures as in the correction of deformity, and certainly not where the extension is poorly applied, or with ill-fitting apparatus. But the claim is made that in ordinary cases a breach of contact does occur, and that this may happen even after disease has existed for some time; that this means affords relief to the spasmodic condition which is the source of so much suffering in the course of acute disease, and its influence is beneficial, not only by alleviating the pain, but also by preventing to a greater or less extent, the mechanical injury to the diseased parts, from this condition of excessive muscular irritability.—*Boston Med. and Surg. Jour.*, March 18, 1890.

Young (J. K.) on Tenotomy for Talipes.—Immediately following a well-performed subcutaneous operation a very little blood is effused into the space from which the upper part of the tendon has retracted. If much blood be effused it retards or defeats the formation of the proper exudate, this latter being not an organization of the blood-clot but a specially formed reparative substance. The first result of this division is the effusion of a fluid or semi-fluid inflammatory lymph exudate. The adjacent blood-vessels enlarge and the tissues about the wound become infiltrated, yellow, and succulent. This exudate takes no part in the reparative process, and usually ceases in twenty-four hours. Somewhat later, about forty-eight hours in rabbits, the proper reparative material makes its appearance (the inflammatory exudate ceases or degenerates) and fills the entire space between the divided extremities of the tendon and ensheaths them both for a short distance. This gradually becomes firmer, stronger, and grayer, and about the fifth day forms a distinct bond of union between the ends of the tendon. The differentiation gradually advances, at first rapidly, later more slowly, in time becoming identical, even microscopically, with the original tendon. The most interesting feature of the process, however, and the one bearing directly on the subject, is that pointed out by some recent investigations performed under the supervision of Victor Horsley, which demonstrated conclusively that if the ends of a tendon be separated a very short distance but a small amount of exudate fills the space; if they be separated a great distance, the entire space is filled in; and if they be separated at first

but a short distance, or the ends remain in contact and are subsequently separated, the resulting tendon will be a weakened spindle-shaped tendon, from a stretching out of the plastic exudate.—*Am. Jour. Med. Sci.*, April, 1890.

Thomson (J.) on a Case of Progressive Idiopathic Muscular Atrophy in a Young Child.—The patient was a girl aged four years and five months. At twelve months of age she was a remarkably fine strong child, and had then for two months been able to walk round the room holding on to the chairs. The weakness began soon after in the legs, and before she was two and one-half years, she could not stand at all. When two years and four months old, she was in the Children's Hospital under Dr. Playfair, and at that time her arms and neck were unaffected. They became affected, however, about a month later. During last year the general weakness had increased slightly, but there was no great change. There was no history of any similar affection in any member of father's or mother's families. The child's attitude was strikingly expressive of her profound muscular debility. There was no extreme wasting of any muscles, nor any trace visible of hypertrophy or pseudo-hypertrophy. The feet were distinctly pointed, and the fingers had a tendency to become hyper-extended. There were no sensory symptoms except diminishing sensibility to pain; the organic and skin reflexes were normal; the knee-jerks were quite absent. The voluntary muscles of the trunk and limbs were all, or nearly all, affected more or less. Those concerned in ordinary respiration, speech, and deglutition, and those of the face and eyes, seemed unaffected. There was very little power of movement left in the legs and loins, and the back, abdomen, and neck were also extremely weak. The shoulders and arms were less affected. Most of the muscles seemed about normal in size; none were much wasted, and none visibly enlarged. A few felt harder than normal; the calves had the feeling of fatty tissue. Coördination was perfect. Electrical excitability had been tested by Dr. Milne Murray, who found the faradic irritability considerably impaired, and the galvanic reaction much more so—in fact, scarcely to be obtained. The legs and feet were constantly cold. The case was regarded as probably one of primary myopathy belonging to the class described by Professor Erb as the "juvenile form" of progressive muscular atrophy, but the pathology of it was very obscure. It differed from the previously published cases in many points, and the patient was very much younger than in any recorded case of any thing like equal severity.—*Ed. Med. Jour.*, May, 1890.

OCCASIONAL REPORT ON GYNECOLOGY.

BY JOHN S. HAWLEY, M.D.

Ross (J. F. W.) on a Case of Hæmatocele of the Broad Ligament Cured by Vaginal Puncture after Suppuration Had Occurred.—The patient, I-para, æt. twenty-two, had fallen from a swing to the ground, landing in a sitting posture, two weeks previous to the time when first seen by the author, and at about the middle of her inter-menstrual period. She was immediately seized with severe hypogastric pain, faintness, and rectal tenesmus, and was unable to assume an erect posture. She was unable to empty the bowels, although the desire so to do was marked. During the night severe griping pains in the abdomen occurred, the former pain having subsided, and the patient became feverish. When first seen by the author she was much exhausted; temperature 102° F., pulse 100. She could retain nothing in her stomach, and was passing bloody mucus from the anus every few moments. A large fluctuating mass could be felt to the left of and behind the uterus, and extending to the utero-sacral ligaments, producing a tense band across the rectum. Enemata had not been effectual in the attempts made to evacuate the bowel, nor had the use of cathartics. Believing that pus was present in the pelvic tumor, a trocar was thrust into the most dependent portion of the mass, giving exit to a tarry fluid, mixed with pus. The opening was enlarged with the flat point of the Pacquelin cautery, the vagina was washed out and packed with iodoform gauze. This was repeated daily until recovery of the patient after about a month's time.

There are two or three points that bear out the clinical history of such cases as recorded by others.

1. The sudden onset of the symptoms after some violent injury or exertion.

2. The sudden obstruction of the rectum through tension of the utero-sacral folds.

3. The peculiar mucous discharge, like pink-stained white of an egg, as diagnostic of rectal irritation. The author had seen this symptom in other cases, and especially in a case of an abscess in a male, between bladder and rectum.

4. The good effect of operation, both immediate and remote. In cases with the fluid high up away from the vagina, the author would always open them through the abdominal wall.—*Canadian Pract.*, Feb. 1, 1890.

Goffe (J. R.) on Four Cases of Supra-Vaginal Hysterectomy with New Method of Treating the Pedicle.—The four cases presented pretty much the same clinical picture as was to be found severally in patients suffering with fibroid of the uterus. The principles, as carried out in each case, did not differ very materially. After making the usual incisions, as in laparotomies, the bladder was separated from the face of the tumor down to the vaginal junction. An elastic ligature was then thrown around the entire mass, which included the ovaries and tubes. The main part of the tumor was now cut away, and the pedicle transfixed on either side, the same as the pedicle of an ovarian tumor. There had been no hemorrhage after the removal of the elastic ligature. The stump was trimmed down and the opening of the cervical canal thoroughly cauterized. The flaps of the peritoneum were brought up well over the stump and firmly and closely stitched with continuous catgut suture. The stump was, by this means, shut out of the peritoneal cavity. It was replaced in the pelvis and the abdominal wound closed. There had been no trouble in these cases until the third or fourth day, when symptoms of suppuration had come on. The patients were then at once placed on a table and the cervix dilated, which allowed of pus drainage and irrigation. From this on the patients had made uninterrupted recoveries. The advantages of this method were, that it had all of the elements of safety, and that it left no ligatures in the pelvis to give trouble, and that it restored the organs to their proper relations in the pelvis. The operation could with truth be called the intra-abdominal, but extra-peritoneal method.—*Times and Register*, Feb. 3, 1890.

Baldy (J. M.) on a Case of Ectopic Pregnancy without Characteristic Symptoms.—The patient was operated upon for double pyosalpinx, and there were removed a small ovarian cyst and an ectopic gestation sac of about seven weeks' growth, from the left and right sides respectively. The points of special importance are as follows:

First. That this was an unruptured or primary tubal pregnancy.

Second. That there was no missed or scanty menstrual period.

Third. That there was no decidual discharge.

Fourth. That there were no breast or stomach symptoms, or other signs of pregnancy.

Fifth. That the woman did not think she was pregnant.

Sixth. That the uterus was of normal size.

Seventh. That the character of the pain was not markedly distinctive.

Eighth. That there was a tubal pregnancy on one side and an ovarian cyst on the other.

The case is one more illustration of the impossibility of an accurate diagnosis in ectopic gestation, and of how such a condition can exist without showing enough symptoms to cause even a suspicion of its existence.—*Med. News*, Feb. 15, 1890.

Wallace (Thomas) on Hydatids of the Pelvis.—The patient, a woman, aged thirty-nine, had been married eighteen years, and had never been pregnant. She had suffered for six years from a feeling of weakness and weight in the abdomen and general ill-health, and for five years had noticed a lump in the right iliac region. Its growth was gradual and unattended with pain, and menstruation had always been regular. The swelling was round, freely movable, and resonant on percussion. Bimanually it could be rolled about; while behind the uterus was another mass, apparently distinct from the first. The uterus measured one inch and a half in length. The case was looked upon as one of ovarian cyst. The patient was operated on in the Cardiff Infirmary by Dr. Wallace. The omentum and intestines were found loosely adherent to the front of the tumor, while the mass itself was closely incorporated with the uterus and bladder below and to the right. After separating the omental structures, the upper part of the swelling was punctured, and this at once showed

the cyst to be hydatid. After its complete removal—a pedicle having been formed out of part of the right broad ligament—a smaller cyst was discovered deep down in Douglas' pouch, containing whitish fluid with some calcareous matter resembling powdered eggshell. These contents were carefully removed, the peritoneum cleansed, and the abdomen closed. The patient, however, died from septicæmia on the fourth day. The necropsy showed that the cysts had been completely removed, and suggested that a drainage tube might have been used with advantage.—*Brit. Med. Jour.*, Feb. 22, 1890.

Palmer (C. D.) on Papilloma of the Bladder in the Female.—The author cites four cases of this affection which had been under his care, one being treated by dilatation of the urethra and scraping the growth away by the finger-nail after the index finger had been introduced into the bladder through that canal, and the other by vesical irrigations with hot saturated solutions of boric acid every other day, combined with the internal administration of a mixture containing boric acid, hyoscyamus, and infusion of buchu. These later cases all recovered without surgical interference, but the former case exhibited symptoms of recurrence of the growth within a year's time, and was again operated upon, the growth—which involved another part of the vesical mucosa than that originally implicated—being scraped away after vaginal cystotomy had been performed, in order that free access to the tumor might be thus afforded. Two years subsequent to this, the patient died from an extension of the disease, involving the whole bladder. In all the cases the diagnosis was made while the tumors were small and early in their histories. The author thus states his views on the subject:

Papilloma of the bladder always causes, even in its very early development, some hemorrhage. The differential diagnosis between renal and vesical hemorrhage is not always easy. When the growth or growths are too small to be made out by physical examination, the evidence must rest upon the seat of localization of pain, etc., the pressure of vesical tenesmus, much mucus in the urine, the bright red color of the urine, and the comparatively small amount of urine and the absence of tube casts. The microscope will aid when the villous formations break down.

Papillomata of the bladder are, without doubt, more frequent than is generally supposed. In the region of the bladder, these tumors take on a soft variety, which, if situated externally and at some accessible point, possess but little pathological significance. They do not have a tendency to glandular affection or dissemination, and the infiltration of the adjacent mucous membrane and submucous tissue is probably inflammatory. On the part of the bladder, hemorrhage is the first, the chief, and the most constant symptom and result. It is the hemorrhage which gives to these growths their most important pathological significance. Complete removal is not always easy, and, if not done, recurrence is sure. The possibility of an epithelioma developing from a papilloma must not be forgotten. Reliable authorities say there is no relief for this affection; that it will destroy life in two years. It is doubtful whether this view is strictly correct. In the majority of cases, it is unquestionably true; but some, there is reason to believe, are curable. These growths are in their anatomical and microscopical features innocent; but, on account of their location, their inaccessibility, the serious and persistent hemorrhages which they create, their strong tendency to return through imperfect or incomplete removal, and, finally, the possibility of a degeneration into epithelioma, they are, in a general sense, malignant.

If dealt with surgically they should be attacked through an opening made in the vesico-vaginal septum rather than through the urethra, as the former is easier, never followed by evil results, and affords rest to the bladder during the after-treatment. The latter procedure is not infrequently followed by permanent incontinence of urine through the tearing away of the urethra from its attachments.—*Times and Register*, March 8, 1890.

Reynolds (Edward) on a Case of Rudimentary Uterus.—The case deserves record for its rarity. A well-nourished, well-developed girl of nineteen came to the Staniford Street Dispensary with the statement that she had never menstruated, and that her family physician had told her that she was "imperfect." Inspection showed, to all appearance, a normal virgin vulva, and the examining finger, though at once arrested, did detect a small opening which suggested an unduly small central

perforation of a rigid hymen. On closer inspection, however, it was apparent that the space where the introitus vagina should have been was occupied by a shallow depression, which, when pressed upwards, became converted into a funnel-shaped cup with the meatus urinarius at its apex. On suspension of the pressure the meatus returned to its normal situation; but it was evident that had coitus been attempted and persisted in, it must have effected a dilatation of the urethra, such as has been observed in other similar cases.

Bimanual palpation, through the rectum, detected a small uterus not more than one third of an inch in length, from which a slender cord, representing the vagina, could be felt to run forward and downward for a short distance. The Fallopian tubes were small but very distinct, the cervix more developed than the body. The lower opening of the vagina was found only after long search, where a slender uterine probe detected an opening in the posterior wall of the urethra about one half of an inch above the meatus, and on passing into it was perceived by the rectal touch to reach the cervix through the slender cord (tube) before spoken of.—*Boston Med. and Surg. Jour.*, March 13, 1890.

The Pessary of the Future.—When it comes to pessaries, the medical profession, like ancient Gaul, is divided into three parts: one comprising those who use and believe in the instrument—stalwarts of the stalwarts, another composed of the natural foes of the pessary and the disgruntled or apostate deserters from the first faction—such as are denominated in the language of statecraft "Mugwumps"; and a third, independent or "floater" party, from the ranks of which the leaders of the two others are wont to draw temporary reinforcements in "blocks of five" when engaged in strife with each other. This is of common occurrence, and the conflicts between the advocates and the opponents of pessaries are fierce and uncompromising, but singularly indecisive withal. The warfare is remittent in type, and never entirely in abeyance; it hath not charity, so that the clash of the hosts meeting in grim combat is remarkably isotonic with the clang of smitten brass—sonorous, but lacking the delicate shades and variations of harmony that appeal to the soul of the true lover of music. On the contrary, the war is waged with all the venom and malignity of a family feud, with verbal instead of leaden arguments, delivered with all the "damnable iteration" of the Winchester repeating rifles used in such instances. From this remarkable property of inducing, as by catalysis, a would-be internecine warfare between those who wot somewhat of its ways, the modern pessary of protean morphology and diversity of material may be said to surpass even the obstetric forceps and the vaginal speculum as a means of evoking the inventive genius and the innate pugnacity of physicians, not only stimulating healthy functional action, but constituting a perennial theme for discourse writing, by which the lecturer, the medical-society orator, and the medical journalist are enabled to strike the most responsive and sensitive chords in the hearts of those to whom their words are addressed, be they words of execration or of fulsome praise of the instrument.

Now, the enemies of the pessary are sweeping in their denunciations of that appliance and of all who use it. Indeed, they regard it as a crystallization of the infinite misogeny of the paternal source of mendacity developed by that arch enemy of mankind during the forced inactivity resulting from a "ten good deeds or ten centuries in the hole" sentence imposed upon him for disorderly conduct, and at a time when his utter inability to produce even a tithe of the requisite sum of the fine forced him to accept the alternative. Free from the necessity of scrutinizing the river and harbor bills and the like passed in Pandemonium relating to the construction of asbestos breakwaters and piers at Avernus Landing, he gave his whole mind to the matter, and, having experimented upon Astarte and Hecate, at last devised the pessary as the most efficient means by which he might bruise the heels (and incidentally the utero-sacral ligaments) of the daughters of Eve. They also aver that the Hogarthian line of beauty characterizing the profiles of many pessaries is evidence of an obliquity of moral nature and of devious ways of conduct, enabling the instrument to trundle merrily through the ample entrance and over the smooth roadbed of the boulevard leading to destruction, but causing it to become wedged inextricably at the very threshold of the narrow gateway to the footpath of righteousness and to serve as a stumbling-block to those who would enter with it. The

other faction enthusiastically laud the pessary as the gift of a beneficent Providence, and hold that the evil ascribed to it by its enemies is a result of their own ignorance and lack of skill in using it; in other words, that the mote which they allege to be visible in the pessary's eye is only a derivative from the rough, dust-laden beam projecting from their own orbital cavities; and, moreover, that, if the theory of the infernal origin of the instrument is correct, its detractors must be the special agents chosen by the foul fiend to execute his designs, for the pessary only fails to give satisfaction when improperly and clumsily used, and no one who understands its use has any reason to do aught else than thank God for it. And so on rolls the tide of battle, and is no nearer an end than when it began.

But now comes a powerful ally to the aid of the pro-pessary party in the shape of a report of the history of a case of insanity cured by means of a pessary inserted by an English physician, supplemented by the relation of a similar cure by one of his colleagues of well-known eminence as an obstetrician and gynæcologist. Of course, this signal advantage will be met by the sneer of incredulity or the scoffing "credat Judæus" of the enemy, according to the individual's custom of accumulating a store of golden silence or of dissipating a fortune of silver speech; but it must be proved that the pessary in its relation to insanity is in an ætiological rather than a remedial position before the effect of this great victory can be counteracted. Much excitement has already been caused by the report in professional circles, and there is to be expected an early movement on the part of those free-lances whose pessaries are advertised widely and vaunted as articles without which no woman can properly or consistently fulfil her destiny and continue a God-fearing existence, in the form of inordinate statements as to the sustaining powers of their respective instruments on the reason when it totters on its throne, and of allegations that their gentle upholding influence will minister unto the mind diseased synchronously with their special function of stretching out a helping hand to the fallen uterus.

The Commissioners of Lunacy should be required to ascertain the pessary-reaction in every case of alleged mental unsoundness in a woman before she is committed to an asylum, and it is not too much to predict that the strait-jacket and the padded cell will vanish from the women's divisions of our asylums, where the melancholic shall lie down with the acute maniac, the hystero-epileptic cease from troubling, and the medical attendant be at rest. His hypodermic syringe shall be dry and incompetent, and he shall satisfy the demands made by delusions of grandeur and power, not by fictitious endowment with the sceptre of the universe, but by the application of a remedial Albert Smith pessary or a Meigs' ring—the symbol of eternal completeness and order. It can scarcely be doubted that such an alienistic millennium for women is at hand, and it may be that investigation will bring out the fact that masculine reason may be saved from the shattering power of paresis and mania by the timely application of a suspensory bandage or by the life-giving emanations of a galvano-faradaic perineal pad. There are almost limitless possibilities suggested by only a superficial consideration of this subject of the pessary in its neurological capacity. It should be earnestly and thoroughly investigated in a spirit of scientific research, and ancient prejudice and obstinate dogmatism should not be permitted to pervert the action of an unbiased judgment of the value of plain facts as indications of the broadening field of usefulness now opened for the pessary of the future by this discovery.—*N. Y. Medical Jour.*, April 5, 1890.

OBSTETRICS AND DISEASES OF CHILDREN.

Dickinson (R. L.) on the Time-Element in Saving the Perinæum.—The author's deductions are drawn from a personal study of 147 cases, and he invites attention to the following salient facts: 1. Primiparæ; slow delivery of head; lacerations, fifteen per cent. (the usually quoted ratio is twenty-one to thirty-four and a half per cent.) 2. Primiparæ; thirty-three slow forceps deliveries; lacerations, twenty-four per cent. (many bad cases). 3. Multiparæ; slow delivery; lacerations, six per cent. 4. Multiparæ; nine slow forceps deliveries; lacerations, none. 5. Multiparæ; rapid delivery; lacerations, thirty-three per cent. 6. Primiparæ; rapid delivery; lacera-

tions, seventy-seven per cent. 7. Ten rapid extractions of head; lacerations, one hundred per cent. (mostly breech cases). 8. Forty-nine forceps operations; lacerations, twenty per cent. 9. Only one rupture into rectum.—*N. Y. Med. Jour.*, April 5, 1890.

Handfield-Jones (M.) on Cardiac Insufficiency in its Relation to Abortion.—The theory of abortion. It is not difficult now to follow out the course of events and see how premature expulsion of the ovum is effected. The first factor in the chain of events is the enfeebled power of the left ventricle; as a result of this the blood stream no longer passes briskly through the small vessels of the periphery, but is driven in a sluggish manner from artery to vein. The inevitable effect of this is, that the walls of the arterioles and capillaries rapidly deteriorate, commence to bulge, and then to leak, and thus blood extravasations are frequently permitted. This process is seen to perfection, if a piece of pia mater or omentum, through the vessels of which a sluggish blood current has been passing for some time, is examined under the low power of a microscope: bulging and spoilt vessel walls are seen everywhere. Each small extravasation between the uterine wall and the membranes of the ovum separates the latter partly from the uterus, and when sufficient separation has occurred, the ovum becomes practically a foreign body, and as such is cast off, or, in other words, abortion occurs. Confirmation of the correctness of this theory, namely, that the ovum is gradually separated from the uterine walls by these small extravasations, is afforded by the clinical fact, that small and repeated blood losses *per vaginam* often take place in these cases for many days before final expulsion of the ovum occurs.

Treatment.—If we accept the views propounded as correct, our treatment becomes at once clear. It is briefly to spare the heart as much as possible by maintaining the recumbent posture largely and avoiding any severe muscular exercise, at the same time by good hygiene, liberal diet, stimulants, and cardiac tonics to improve the nutrition of the organ.

In many of our text-books on midwifery and diseases of women, the term "habit of abortion" is mentioned; the term is essentially a term of ignorance, and we find that as our knowledge becomes more exact, fewer and fewer cases of repeated abortion are referred to this category, other and more scientific explanations being forthcoming. Should the view here put forward to explain the causation of some instances of repeated abortion be deemed a true and scientific explanation, it may serve to rescue some of our hitherto unexplained cases from the unfortunate group referred to, and by making clear the mode in which abortion is brought about, may lead to a satisfactory and successful treatment.—*Br. Med. Jour.*, March 15, 1890.

The Obstetric "Binder."—An interesting discussion took place on this subject at the Obstetrical Society, the abstract of which will be found in *The Lancet* for March 15th. The alleged uses of the binder cited by the reader of the paper (Dr. Herman) were (1) comfort,)2) maintenance of the intra-abdominal pressure, and (3) preservation of the "figure." The maintenance of the intra-abdominal pressure has been thought to prevent flooding. As to this, the author did not believe that this effect could be relied on, and some speakers agreed with him. The bulk of the paper concerned measurements of the base of the chest, which was shown to be practically unaffected by the binder. The conclusion arrived was that, except as regarded the comfort of the patient, the use of a binder was a matter of indifference. As one of the speakers pointed out, the meaning of "waist" and "figure" varied with the fashion; but the Society seemed to think that the support of the abdomen during the post-partum involution of its walls was not a matter of indifference, and that the binder was, after all, a valuable safeguard against "pendulous belly" when properly used.—*Lancet*, March 22, 1890.

Tait (L.) on the Surgical Aspect of Impacted Labor.—The author for various reasons is inclined to abandon embryotomy, evisceration, and other mutilating operations where the fœtus is viable and the impacted labor is due to pelvic deformity, and prefers to resort to a modified Cæsarean section, the chief modification being amputation of the uterus after the removal of the child and placenta. This operation certainly has the advantage over other Cæsarean sections, in that it effectually prevents the deformed woman from again becoming pregnant.

He describes his operation as follows:

The first step in the operation is the

abdominal incision, four inches in length, involving first the skin and then the muscles down to the sheath of the rectus, all of which ought to be divided by a sharp knife at one blow; then the tendon of the one or other of the recti is opened, the muscular tendons fall aside, the posterior layer of the tendon is nipped up by two pairs of forceps and divided between them. The extraperitoneal fat is treated similarly, then the peritoneum raised again by two pairs of forceps, a slight notch being made between them; and the moment this is effected air enters, and all behind falls away. No director is required, nothing but an observant pair of eyes, lightly applied forceps, and a delicately applied, sharp-cutting knife. The finger is then introduced into the peritoneal cavity, and the relations of the uterus and bladder exactly ascertained. The peritoneum is then opened to the full extent of the four-inch incision, and the cut edges of the peritoneum are seized on each side by a pair of forceps, and are pulled severally to the respective sides. No better retractors can be employed.

The piece of india-rubber drainage tube, about eighteen inches or two feet long, is now held as a loop between the fore and middle finger of the left hand, and is by that means slipped up over the uterus and pulled down over the cervix, passing the fingers behind the cervix to see that coils of intestine are not included in it. One hitch is then made on the tubing when it has been got as far down as possible, and it is pulled as tight as is consistent with safety. The second hitch may be made in it, but what is far better, an assistant keeps the tube on the strain, so that the one hitch will be quite enough to effect the most efficient clamping.

A small hole is then made in the uterus, just large enough to admit the finger; if it is possible, the position of the placenta may then be ascertained; if not, the right forefinger follows its colleague, and between the two, by gentle rending, an aperture is made in the uterus, and the leg of the child is seized. The fœtus is then carefully delivered feet first, and this, despite all the authorities to the contrary, is by far the best proceeding; less blood is lost, and it requires but very gentle manipulation to relieve the head.

As soon as the fœtus is removed, the placenta is sought for, and removed similarly; the uterus itself being then completely contracted by this time, is pulled out of the wound, and the elastic ligature is tightened once more, and finally arranged round the cervix, and the second hitch is applied. The main details of the operation are now completed; all that is required is to pass the needles through the flattened tube and through the uterus, and out at the other side, forming a St. Anthony cross, or two parallel bars to support the weight of the uterus and the stump, and to keep it outside the wound. A complete toilet of the peritoneum is then made, not forgetting the anterior vesical *cul-de-sac*; stitches are passed in the ordinary way to close the wound accurately round the uterine stump.

The uterus is now removed close down to the needles and strangulating rubber tube, so as to leave a little tissue above. It does not do to run any risk of the ligature slipping off, though this is hardly possible after the needles have been placed carefully through the structure of the tube. A little perchloride of iron is then rubbed gently over the surface of the stump; it is dressed with dry lint and some dry cotton gauze, an ordinary obstetric wrapper is put on, and the operation is at an end.—*Brit. Med. Jour.*, March 22, 1890.

Gardiner (P.) on Complete Transverse Laceration of the Womb.—Mrs. H., aged thirty, a negress, who had always enjoyed good health, and had previously on different occasions given birth to four children in a normal manner, was taken in labor at the full time under the care of a midwife. The pains were stated to have been regular, and the membranes ruptured early, but at no time could the midwife feel the presenting part of the child. The pains continued for twenty-four hours, and then became weak and irregular, the midwife following this up with ten minims of ammoniated tincture of ergot., which had the effect of stimulating the uterus for a brief period. Still the abdomen remained as large as ever. Again the midwife resorted to ten minims of am. tinct. ergot., which brought the pains on rapidly, and ended with one especially severe pain. This occurred on the evening of the second day of labor. Another similar dose of ergot a few hours later failed to excite contractions. I was summoned to the patient on the evening of the second day of labor, and found her in a state of collapse, her abdomen tender, and the appearance of pregnancy at full time.

On making a vaginal examination I could make out nothing definitely with my finger, but on introducing my hand along the vagina I found it had entered the abdominal cavity, and on manipulation the womb was found to be completely torn through at its neck, the laceration extending round the uterus, thus dividing the neck from the body, the latter part lying high up in the abdomen, with an irregular gaping mouth, through which I could introduce my hand, and containing nothing beyond a few clots of blood. Lying alongside the uterus I could easily make out a fœtus of large size. I seized a foot and turned, but the head got locked at the brim, and I was obliged to perform craniotomy. The child was well formed, of large size, and of the male sex. Again I introduced my hand into the abdominal cavity to remove the placenta, and could easily lay hold of the body of the womb, my fingers repeatedly gliding off the slippery serous membranes. As I passed my hand round the organ I could make out that the vesico-uterine ligaments were torn through and the left broad ligament partially torn. The pelvis was small, though not abnormal. No history of syphilis or cancer could be obtained. The woman never rallied, and died a few hours after delivery.—*Br. Med. Jour.*, March 29, 1890.

Robertson (J. C.) on the Gariel Air-Ball Pessary as a Plug in Abortion.—I wish to call the attention of practitioners to the use of the Gariel air-ball pessary as a plug in early abortion. The idea is not original. I saw it casually mentioned some years ago in one of the medical papers, but, as far as I can ascertain, few are aware of the advantages of this instrument. In those cases where the ovum is not completely detached, and is, moreover, out of reach, and hemorrhage more or less alarming is going on, the best results follow the use of the air-ball pessary. The ordinary process of plugging by pledgets of wool or by prepared tampons is laborious and precious time is lost. On the other hand, one can introduce the air-ball pessary and inflate it in half a minute; the upper vagina is most effectually plugged, and the patient can be left with safety for a couple of hours or more. The presence of the pessary is a powerful excitant of uterine action, and one usually finds at the next visit the ovum detached and lying on the top of the pessary. I have used this instrument on several occasions, and always carry one in my obstetric bag. Before insertion it is well washed with a solution of corrosive sublimate, and then smeared with an antiseptic lubricant.—*Lancet*, April 5, 1890.

Unusual Mechanism in Shoulder Delivery.—Dr. James L. Kortright, of Brooklyn, reports to the *Med. Record*, April 19, 1890, the following case: Mrs. L——, aged twenty-two, multipara was delivered February 28, 1890, of a large male child. The only point of interest was in the birth of the shoulders. After the head was born, restitution took place, with the child's face looking toward the maternal right thigh, as is normal in first position of vertex. The anterior shoulder lodged above the symphysis pubis. Delivery was finally effected by the anterior shoulder rotating into the hollow of the sacrum and the posterior and lower shoulder passing under the pubic arch, so that the child's body made a complete semi-revolntion and the face at last looked toward the maternal left thigh. In the revolution the face turned toward the bed.

Harris (J. H.) on Scarlet-Fever and Puerpera.—The patient, a woman, was confined for the first time Monday, March 3d. She was attended by a midwife, and parturition was normal.

She was, March 7th, suffering from great pain in the abdomen, which was greatly distended and very tender to the touch, especially over the region of the uterus, which was contracted to the size of a fœtal head. The lochia had ceased, and there was no milk in the breasts; the tongue was dry; the bowels had not been opened since her confinement. Pulse was 120; temperature 102.8°. She was also covered from head to foot with a scarlet rash, and had a sore throat, which, her attendant told me, came out on the day previous (Thursday). I ordered turpentine stupes to be applied to the abdomen, and the vagina to be frequently washed out with Condy; and gave her a quarter of a grain of opium and half a grain of calomel every four hours; but she got rapidly worse during the next twenty-four hours. Her temperature went up to 106°, and I could not count her pulse at the wrist. The mouth and throat were so dry that she could swallow nothing; in fact, she seemed *in extremis*. I then injected a quarter of a grain of pilocarpine under the

skin, which acted like a charm. It produced a profuse perspiration, brought the temperature to 102°, but it had no effect on the pulse, which remained uncountable; and she fell into a comfortable sleep for nearly three hours. After that she could swallow a little, although the tongue was still dry and brown. I then put her on a mixture containing sp. am. ar. ℥xx, tr. digitalis ℥x, pot. bromid. ℥v, aquam ad ℥i, every four hours, together with alternate meat and milk suppositories and small quantities of milk and brandy by the mouth, and continued the vaginal washing; and, since the hypodermic injection, she has steadily improved. Her pulse is now 80, and temperature 98°, and she is desquamating freely. Her urine contains a large quantity of urea, but, as yet, no albumen.

In this case I found, on inquiry, there had been two children in the same house who had recently had sore throats and red rashes, but the mother did not think them ill enough to call in the doctor. The infant has had, as yet, no sign of scarlet-fever.—*Br. Med. Jour.*, March 29, 1890.

Purdom (J. F.) on Pertussis and its Treatment.—When I have diagnosed the case I prescribe fl. ext. ergot., given in wine or brandy, if objected to in water, every two to four hours, according to the severity of the symptoms; to a child of three months, five-drop doses, and to older children in proportion to age; and, as the urgent symptoms abate, I lessen the dose or extend the time, but continue the ergot until the spasmodic cough has ceased. My confidence in the curative effect of ergot is so settled that I tell the parents that so sure as they give the medicine as directed they will find improvement in the spasmodic cough inside of seventy-two hours. As a palliative in the early stage, I give in conjunction with the ergot a simple cough mixture, composed of equal parts syr. ipecac, syr. squills, camphorated tinc. opium, and aromatic spts. ammon., with double the part of syr. tolu; dose according to age, and repeated as necessary to relieve the tenacity of the mucus and give rest at night. I regard it necessary as far as possible to have proper ventilation of the living apartments, with out-door exercise when the weather will permit. The feet should be kept dry and the body clothed with flannel during the course of the disease at all seasons, except the hot months of summer. With a good generous diet, I recommend all such hygienic measures as would tend to promote vigorous health. As will be at once seen, I do not claim any specific action for ergot, but believe it relieves congestion of the vessels about the medulla oblongata; also constringing the vessels of the parts invaded by the micro-organism, making the soil less fertile and the tenacious secretions less abundant, thereby making the enemy's stay of shorter duration, and at the same time cutting off his avenues for producing complications by lessening reflex irritability.

I have treated one hundred and three cases of whooping-cough with ergot and a simple cough mixture, and without a death. I have had neither capillary bronchitis, pneumonia, nor convulsions to arise after treatment was begun. Neither has there been any hemorrhage worthy of note. The spasmodic cough has lasted from seven days to four weeks; and there has been seldom a tonic course of treatment required in the stage of decline, as a result of anæmia or retarded convalescence.—*Am. Pract. and News*, April 12, 1890.

Kjos (K. A.) on an Accident in Midwifery.—I was called some ten miles into the country to see an infant that had received an injury at the time of its birth.

Entering the house I was first greeted by the happy mother of the child, but near the stove sat a woman, the midwife, seemingly in great agony, as the tears were coursing down her pale and haggard cheeks.

I kindly inquired the cause of her grief, when she suddenly in a cry exclaimed: "Oh, the baby is hurt, but I used no instruments!" Without further questioning I demanded the privilege of an examination, which was permitted after first taking particular care to prevent the anxious mother seeing the procedure.

To my great surprise I found the scrotum lacerated and the testicle protruding and greatly enlarged.

On further inquiry as to the history of the case, I learned that it was a breech presentation, and the midwife, not recognizing the fact, took the presenting parts for the bag of water, and in attempting to rupture it had taken hold of the scrotum with thumb and index finger, and thus by a twist of the hand the unfortunate accident occurred.

The spermatic cord was ligated and the testicle removed, and the child recovered in about three weeks.

I trust that he in the future will have no kindly feeling for midwives, but urge the employment of regular physicians for cases of similar character.—*N. W. Lancet*, April, 1890.

REPORT ON DISEASES OF THE NOSE AND THROAT.

BY CHARLES H. KNIGHT, M.D.

Semon (F.) on Empyema of the Antrum.—In rare cases disease of the antrum may be primary; in the vast majority it is secondary to disease of the nose or of the teeth, the latter being the more frequent origin. The diagnosis rests upon the occurrence of unilateral periodical fetid discharge from the nostril, excited by causing the patient to lie upon the sound side with the head dependent. Pus may be seen issuing from the ostium maxillare, or, in case that passage is occluded, there may be distension of the inner wall of the cavity, accompanied by violent neuralgic pains in the face and teeth on the affected side, and sometimes by swelling and redness of the soft parts of the cheek. If necessary, an exploratory opening may be made through the nose, the socket of a tooth, or the alveolus, preferably by one of the two latter. Heryng's test by means of an electric lamp introduced into the mouth may be resorted to. On the sound side the maxilla appears red and translucent, while the affected side is dark. Semon prefers treating these cases by opening the antrum through the mouth. In obstinate cases a counter-opening should be made in the nose, and in case of failure a large opening should be made in the canine fossa and the antrum stuffed with iodoform gauze.—*The Medical Press*, Jan. 8, 1890.

Friedländer (A.) on Empyema of the Maxillary Sinus.—In Krause's clinic the best results are obtained by opening the antrum with a trocar through the inferior meatus. The cavity is first cleansed with a boric-acid solution, until the returning fluid is free from pus. The solution all having been expelled by forcing air into the sinus, the cavity is thoroughly insufflated with powdered iodoform. In several cases the duration of treatment was but little more than two weeks.—*Berl. klin. Wochenschr.*, Sept. 16, 1889.

Carr (W.) on Diseases of the Antrum.—The author's experience tends to show that in a large majority of cases suppuration of the antrum is due to diseased teeth. He objects to opening the sinus through the inferior meatus, since it seems to be a more serious operation, and moreover does not give as good opportunity for thorough cleansing. He advises opening through the alveolus, even at the expense of a sound tooth, by preference the second molar. The free use of a ten-per-cent solution of cocaine obviates pain. The cavity should be cleansed twice daily with a saline or an antiseptic solution. Silver drainage tubes are unnecessary. Several cases are cited.—*Jour. Am. Med. Ass'n*, Dec. 21, 1889.

Horsley (R.) on Cyst of the Posterior Extremity of the Inferior Turbinated Body.—This case is of interest on account of the rarity of the lesion itself, and from the fact that asthmatic symptoms entirely subsided after removal of the cyst. The presence of a tumor resembling a myxoma at the right posterior naris was recognized by means of the rhinoscopic mirror. In further examination with the finger its cystic character was suspected, the suspicion being confirmed by sudden rupturing of the sac, the escape of slightly blood-stained fluid, the instantaneous relief of symptoms, and the complete disappearance of the tumor. Several applications of Mandle's solution of iodine were made to the site of the tumor, and there was no recurrence.—*Edin. Med. Jour.*, Jan., 1890.

Stewart (W. R. H.) on Sixty-three Cases of Growths in the Naso-Pharynx.—In each of these cases one or more of the usual symptoms of the disease, viz., deafness, tinnitus, snoring, nasal speech, the stoppage of nasal respiration, the open mouth, and the peculiar semi-idiotic appearance, prevailed to a more or less degree. The records do not show a *family* tendency to disease of this character, in only two cases other members of the family being similarly affected. The improvement in hearing varied in different cases, in a measure proportionately to the duration of symptoms, and was apparent at once, or began several months after operation. The growths were removed with Woakes' modification of Löwenberg's forceps in every case but one, in which Gottstein's ring knife was used. The latter instrument is preferred. No complications

occurred, except in a few cases, which were allowed to go home within an hour or so of the operation, and who evidently caught cold. The patient should be kept in bed for twenty-four hours. In every case chloroform was the anæsthetic employed. A gentle, warm boracic-acid douche is used for the first twenty-four hours, followed after this period by an alkaline iodine one, which is best continued for some little while. Enlarged tonsils were operated on at the same time, but before the growths were removed; this gives more room.—*The Med. Press*, March 26, 1890.

Renner (W. Scott) on Adenoid Vegetations of the Naso-Pharynx.—This paper, which covers the ground pretty thoroughly, contains nothing new. The author uses Chiari's snare, or Catti's forceps, and prefers Marchoni's mouth-gag. (Some very good instruments are made in America.) The paper concludes with nine propositions relating to symptoms which should lead us to suspect adenoids, to the importance of their early recognition and removal, to the fallacy of allowing patients to outgrow the trouble, and to the desirability of establishing a system of school inspection.—*Buffalo Med. and Surg. Jour.*, April, 1890.

Bronner (A.) on Some Affections of the Pharyngeal Bursa.—Four cases of disease of the pharyngeal bursa are described. Two were treated by repeated applications of chromic acid, and in two the curette was used. The former method, although more tedious, is recommended for "nervous patients." The latter is simple, easier, and quicker. The author uses a modification of Kartman's curette, which may be introduced under the guidance of a post-nasal mirror and with the aid of a Voltolini palate retractor.—*The Lancet*, Jan. 11, 1890.

Delavan (D. B.) on Adenoid Hypertrophy at the Vault of the Pharynx: its Pathology and Treatment.—Two varieties are recognized—acute, or subacute inflammation of the adenoid tissue, and chronic enlargement, true hypertrophy, the latter presenting two forms. In one the adenoid element predominates, the tissues being soft and friable; in the other, the hypertrophied mass is composed more largely of fibrous tissue.

In a few instances, where the disease is acute or subacute, where the tissue is soft, and where the growth is small, or, finally, where the patient is old enough to submit to local treatment, the application of resorptives and the administration of alterative and tonic medicines, together with careful attention to hygiene, may accomplish a cure. Too often, however, these means will be found unsatisfactory, and the question of radical measures will present itself.

The instruments used in the surgical treatment of these cases may be divided into four classes: (*a*) Those made upon the principle of the curette; (*b*) the double curette, or forceps; (*c*) the wire loop; and, finally, (*d*) the adenomatome. The author prefers a modification of Löwenberg's forceps, and the use of the finger-nail. Chloroform is preferred to ether, since the former is free from the objection of exciting the flow of mucus. The patient may be placed in a sitting or a recumbent posture, each having certain advantages and disadvantages. After-treatment is important, the patient being kept in bed for several days, or at least so long as signs of nervous shock persist. It may be necessary to train the patient to keep his mouth closed during sleep by means of a bandage, as suggested by French. Difficulty in pronouncing certain consonants, due partly to relaxation of the soft palate, must be remedied by local treatment and suitable vocal exercises. Finally, deformities of the chest should be corrected by appropriate physical exercise, and nasal deformities should receive attention.

In conclusion, it will appear that adenoid hypertrophy at the vault of the pharynx is a disease of common occurrence; that its presence is fraught with danger, particularly in children during the growing period; that the condition is easily recognized even by those not specially versed in the diagnosis of diseases of the throat; that it is absolutely remediable; and, finally, that by the use of skill and thoroughness in the performance of the necessary operation, the most satisfactory results can be attained.—*Jour. Am. Med. Ass'n*, March 8, 1890.

Kidd (Percy) on a Peculiar Obstructive Form of Laryngeal Tuberculosis Which Simulates Bilateral Abductor Paralysis.—Stenosis, though not one of the commonest, is yet, perhaps, the most important result of tubercular disease of the larynx. In most cases it is due to infiltration, with or without œdema, of some part of the mucous membrane

above the vocal cords. In the variety under consideration, the author having seen six cases, two of which he reports, the stenosis depends upon mechanical fixation of the vocal cords in the position of phonation. The reasons for adopting the theory that the condition is produced in this way, rather than by a paralysis of the posterior crico-arytenoid muscles, are discussed, and the paper concludes as follows:

Fixation of the vocal cords in the median position, simulating bilateral abductor paralysis, may occur in tubercular disease of the larynx, as the result of three different causes:

1. Plastic infiltration around the arytenoid cartilages leading to adhesive perichondritis and spurious ankylosis.

2. Ulceration, followed by morbid adhesion of the altered vocal cords.

3. Suppurative crico-arytenoid arthritis.

To these causes it may be necessary to add a fourth, if, as is not improbable, further investigations should demonstrate the existence of a non-suppurative adhesive arthritis.

In all cases of this description the performance of tracheotomy, or some other surgical measure, is indispensable, and should not be long delayed; consequently the early recognition of this condition is a matter of no small clinical importance.—*Brit. Med. Jour.*, March 29, 1890.

REPORT ON VENEREAL AND CUTANEOUS DISEASES.

Extragenital Syphilis.—Our Vienna correspondent has furnished us with the outlines of a startling paper read last week before the Surgical Society of that city, by the well-known dermatologist, Prof. Neumann, whose personal experiences bid fair to disturb the equanimity of our modern hygienists in the transmission of disease. From presumed innocent sources, Prof. Neumann gives 84 authentic cases that have come under his own observation for treatment. Out of this number he had 18 on the upper lip,—6 male, 12 female. The source of infection was drinking out of glasses that had been used by syphilitic people. The sores ranged in size from a pea to that of a sixpence. Twenty-eight times on the under lip,—9 male, 19 female. The origin of the malady in these cases was mostly by kissing, a custom not unknown in English female society. One of these cases was a bride who had been kissed by the bridegroom, who, three years previously, had suffered from syphilis. Others were children, from aunts, mothers, or fathers kissing them. A father kissed his own son, who was syphilitic from his mother, and thus became infected through the child with hard chancre. The opposite is also given among these. The mother who bore the syphilitic child was free till nursing, when she acquired the chancre on the lip from her infant daughter. In this list also comes one of a woman, eight months pregnant, who was infected by the use of a spoon that her syphilitic servant maid had used, the child also having the syphilitic rash at birth. Twice on the cheek—1 male, 1 female. In the latter the sore was the size of an apple. Eight times on the angles of the mouth—6 male, 2 female. Four times right, four times left. One was due to the smoking of the half of a cigar commenced by a syphilitic. Four times on the chin—3 male, 1 female. By shaving; presumably in the same way as anthrax may be conveyed by removing the inspissated matter at the mouth of a sudoriferic gland, which acts as a cork. Three times on tonsils in males from the use of infected spoons. Twice on the alæ of the nose—1 male, 1 female; from washing in basins formerly used by syphilitic people when the alæ were excoriated. Ten were on the fingers from different causes—5 of either sex. Bites in scuffles, washing syphilitic clothes, etc., were the direct cause. The others are given to nursing, etc., in more detail, and classes the 84 into 34 maculous, 11 papulous, 19 maculo-papulous, and 1 pustular. The disease and its sequelæ were in no way modified by this unusual propagating of the virus. Constitutional disease like this does not entirely depend on the morals of a single individual, but a nation and its sanitary attention.—*Med. Press*, Feb. 12, 1890.

Moss (A. J.) on a Case Simulating Pemphigus.—I was sent for hurriedly late on the night of December 27th last, to see a boy aged nine who had been ill all day. The previous day he had been quite well. On arrival I found him restless, and suffering from slight cough, pains in the legs, and bad headache. The temperature was 100.2°. On examination of the legs, I found over the anterior tibial region of

both an irregular reddened patch some four inches long, on which were scattered numerous small vesicles about the size of a pea. The general appearance of the patches looked exactly like herpes, if such a thing as symmetrical herpes were possible. The bowels being loaded and the tongue foul, I simply ordered a purgative. The mother informed me that she was quite sure the eruption was not present in the morning. At my next visit the boy felt much better; headache and cough had disappeared, and the bowels acted freely. The eruption on the legs had altered in character, the reddened base had faded, but the vesicles had run together to form large bullæ, some of them of the size of walnuts, tensely filled with a clear serous fluid. I now prescribed a little arsenic, and ordered the eruption to be dusted with zinc oxide. In a few days the boy was quite well in general health; the large bullæ collapsed from reabsorption of their contents, and disappeared, leaving a slightly reddened surface to mark their position.

I subsequently found out that the boy on the day of my first visit had been sitting close to the fire all day, and had most probably scorched his legs. But if this be the correct explanation of the eruption, is it usual for the blisters caused by heat to increase so enormously in size after removal of the cause? At first the case was very puzzling on account of the raised temperature, cough, and headache coincident with the eruption. There has been no recurrence of the eruption, and at the present time the patient is perfectly well. —*Lancet*, March 8, 1890.

Sumner (T. O.) on Exelcosis of the Scrotum and Thighs.—There is a very annoying trouble not referred to in medical works and utterly ignored in surgery, which, for the want of any known name I have denominated *exelcosis of the scrotum and thighs.*

No one has ever escaped irritation of the scrotum by friction against the thighs, but in the majority of cases it passes away without lesion, producing only a little erythematous eruption and pruritus. But there are others who are not so fortunate as to get rid of this so easily. A lesion occurs upon the thigh or scrotum at the point of contact. A profuse acrid secretion is poured out which produces that character of eruption which has misled the profession generally into calling it eczema; but it is not eczema. It is a specific local trouble, occasioned by friction and contact between surfaces continuously pressed together, and caused by acrid exudation. This goes on frequently until the intense itching causes violent scratching, which in turn easily produces a lesion. Then this acrid exudation poured out upon the raw surface, soon produces an ulcer, which is often mistaken for a specific venereal ulcer, and in fact it does greatly resemble it in its elevated and hardened angry borders—when round, being almost the fac-simile of the true chancre; but fortunately for diagnosis, there are but few that are regular, most of them being jagged, dentated, and of uncertain shape.

I have called the disease exelcosis, for the reason that the character of the ulceration is excrescent, and one of its most marked peculiarities is the failure to retract molecularly, on account of the peristaltic action of the dartos and the cremaster muscle. This (with the fact that the friction of clothing keeps up irritation) is the reason that these ulcers are so difficult to heal.

The annoyance is almost insufferable. There is constant irritation. Walking frequently throws the ulcerated portion of the scrotum in a position which produces the most acute lancinating pain. It interferes with the natural gait of the person afflicted, and even when sitting he can find no easy or graceful posture. At night the contact of the ulcer with the thigh often sends a shooting sensation through the parts that renders sleep impossible, and any position uncomfortable. When the weather is warm, there is nothing more disagreeable, for, apart from the actual suffering it causes, there is an offensive odor, which, however cautious and cleanly the person may be, can never be got rid of. The thick edges of this ulcer are swollen and inflamed—in a state of hyperæsthesia—and every vermicular or peristaltic movement of the dartos is like the twisting of ultimate nerve-filaments.

In the first place a suspensory is necessary for these patients. The next step is to cover the ulcer with a solution of acetate of lead and opium:

℞ Plumbi acetatis . . . . ʒj.
Tinct. opii . . . . . ʒij.
M.

This should be applied by saturating

wood-fibre cotton and placing within the suspensory to be retained for six hours. After that it should be removed and a dry piece of wood-fibre cotton, upon which about a drachm of calomel has been sprinkled (along with about ten grains of cocaine hydrochlorate, to allay the intense hyperæsthesia of the exposed filaments), applied in the same way as the other. This to be kept on for six hours, removed, and the parts well washed with Castile soap and warm water, and then reapplied.

On the following day the wood-fibre should be saturated with peroxide of hydrogen, or if that is not obtainable, Darby's prophylactic (chlorinated soda and permanganate of potash). This is to be kept up for three days, and after that an application on the cotton of the following:

℞ Ac. tannici . . . . . ʒi.
Balsam. Peruviani . . . ʒj.
Sig.—Apply locally morning and night. M.

When any of these applications are removed, I cannot lay too much stress upon thoroughly cleansing of the parts with Castile soap and warm water, and then drying them well before putting on the dressing.

If this treatment is systematically carried out, the ulcer will heal in two weeks and without much annoyance to the patient; whereas, without treatment it will go on for months without the slightest tendency to heal.

The scars left are ugly and irregular, with deep pits, the floor of which is composed of tissue, not exactly cicatricial, but of a different nature from the normal scrotal skin. It is smooth and shining and quite sensitive to the touch, requiring the use of astringents to thicken and harden it. —*Am. Lancet*, April, 1890.

The Treatment of Psoriasis.—Dr. Henry J. Reynolds, of Chicago, in the *Med. News*, April 19, 1890, advises the following treatment for psoriasis. As the disease is more or less chronic in character, with a tendency to return, naturally very many remedies, both internal and local, have been made use of at various times with a view of curing and eradicating the disease. The disease, as already stated, is always characterized by the same symptoms, regardless of the case or stage of the disease, so that the treatment may be more or less uniform. As in most other scaly eruptions, the first thing to be done is to get rid of the scales. This is best accomplished by the use of (two or three times a day at the beginning of the treatment) some oleaginous preparation, as any simple ointment, combined with the daily use of plenty of hot water and soap, with a rough towel or flesh-brush for the purpose of getting rid of all the scales that have already been softened by the oiling process. When the scales have been pretty thoroughly removed, the best remedy or local application is ten grains of chrysarobin to the ounce of lard, vaseline, or other similar substance. This remedy, to be effectual, must be thoroughly worked into every individual patch on the surface of the body once or twice a day. In two or three days the oiling, soaping, and washing process must again be resorted to, to get rid of the scales which have reaccumulated. By following up this process, almost every case of psoriasis may be cured in the reasonably short space of a few weeks. The other remedies which may be used are pyrogallic acid, citrine ointment, naphthol, etc. As to constitutional treatment, I think the majority of dermatologists favor the use of some form of arsenic. In my own practice I have not used arsenic for six years in the treatment of psoriasis, and, as far as I am capable of judging, I am able to cure the disease just as well without it, or other constitutional treatment, as with it. It may have a tendency to prevent the return of the disease, but I think that even this is doubtful.

Dr. M. P. Vander Horck, of Minneapolis, in the *Northwestern Lancet*, April, 1890, treats the disease with large doses of the iodine of potash, which, he says although not a specific against psoriasis, is of undoubted value in the treatment of this disease. It is equal, if not superior, to the internal use of arsenic, and should be especially tried in cases which have resisted this drug. Also in such cases as have resisted or are unsuited for local treatment. As far as known it has no power to prevent relapses of the disease.

In the large majority of cases it will not be necessary to exceed a daily dose of 24 grms., or 360 grains. These large doses can be given with comparative impunity, but the patient should always be under the observation of a physician. Serious complications which cannot be quickly and completely relieved by decreasing or stopping the drug have as yet not been met with.

No unpleasant or dangerous consequences are experienced on suddenly stopping the iodide, as is the case with arsenic when given in large doses. The drug would seem contra-indicated in cases of kidney disease of any description, because of the irritation set up in these organs by its elimination. The same is probably true to a less extent in serious gastric ailments.

Schact on a Case of Scleroderma of the Breast.—The patient was a single woman, æt. eighteen. Her attention had been drawn to the scar-like patch under the left breast about three months previously by occasional shooting pains, which were worse after using the left arm. It was because of these pains that she sought advice. Her general health was very good, and the only possible exciting cause which suggested itself was pressure of the corset on the part exposed.—*Med. Press*, March 26, 1890.

Kahler (O.) on Urticaria.—Concerning the treatment of this affection the author says:

"The use of medicines is somewhat limited by the fact that an attack of acute urticaria lasts only a short time; on the other hand we have no remedies that have any effect either in its intensity or in changing its course. We can only act on the symptoms, and it is principally the itching that demands our attention. This troublesome sensation is sometimes so violent as to prevent sleep. We will, therefore, try to procure sleep by artificial means, and for this purpose make use of ordinary sleeping remedies. But we are still called upon to furnish some relief to the itching. We have, however, means of acting permanently on it. The use of applications of a two per cent. solution of carbolic acid is the best, which are allowed to remain on for some time. But these only relieve the itching from ten to fifteen minutes, then to return with its former intensity. The simple action of cold on the affected side gives some relief. A very elegant preparation is the aqua laurocerasi in almond emulsion. A popular remedy, one that is much used, and that you can occasionally employ, is lime juice, or slices of lime or lemon laid directly on. But even with these means, the relief obtained is only for a few minutes. The use of warm baths is decidedly unadvisable, as they will only cause the rash to come out with redoubled intensity. As a hypnotic that you can employ I place sulphonal in the front rank; with this sleep can be readily induced; then chloral hydrate; but in cases like the present the condition of the digestive apparatus must always be borne in mind when these remedies are being administered, and when this is affected the medicine may be given *per rectum*. In the chronic form of nettle-rash also we are not justified in brilliant expectation. Salicylate of soda given steadily may act favorably in some cases, and so may frequently bring about considerable amelioration or even cure. On the other hand I have seen no result from atropine or belladonna, recommended by many, and I do not know how it is likely to act. A course of treatment at Carlsbad has been successful in many cases; these were probably such as had chronic catarrhal affections of the digestive tract, as a basis."—*Med. Press*, March 19, 1890.

Ohmann-Dumesnil on Alopecia Areata Due to Traumatism.—In a paper upon this subject the author related the histories of two patients in whom he had observed this condition. In one, the alopecia was caused by a wooden shingle falling upon the scalp and cutting it. In the other, the patient fell off a ladder, and a single patch on his temple appeared. The author referred to the neurotic forms of alopecia areata, and also to that form caused by micro-organisms.—*St. Louis Med. and Surg. Jour.*, April, 1890.

Roberts (S.) on Diffuse Symmetrical Scleroderma.—The malady in this case affected the feet and legs only. The patient was a moulder by trade, aged seventy-two. The disease began in June, 1889, above the left ankle, and spread gradually upwards and downwards. The right leg was not affected until three or four months later. At first the legs were swollen and hard, but not œdematous. When shown, the infiltration of the left leg had been replaced by atrophy of the tissues, and the same change was occurring in the right leg. In both the skin was firmly adherent to the parts beneath, so that it could not be pinched up or moved over the subcutaneous tissue. It was very hard, dry, smooth, devoid of hairs, and of a dirty appearance, with fawn-colored mottling. Both legs were symmetrically affected as far as the knees, but no distinct line of demarcation was visible. The

patient was unable to extend the left knee fully, owing to the rigidity of the skin ; the ankles were fixed, and the toes only slightly mobile. His general health was good, and his chief complaint was of a boring pain and intolerable itching in his hide-bound legs, which interfered with sleep. There was no anæsthesia. The condition of the skin and the itching had improved under ferruginous tonics and friction with oily substances.—*Lancet*, March 8, 1890.

REPORT ON DISEASES OF THE EYE.

A Case of Malarial Keratitis.—A married woman of forty-six called on me November 8, 1889. She was suffering with keratitis, of two weeks' duration. The upper and inner quadrant of the cornea showed a circumscribed interstitial keratitis, while the outer and lower quadrant was studded with phlyctenulæ. There was a small ulcer on the inner segment and general chemosis. There was photophobia and lachrymation ; the pupil responded to light slowly ; the vision was blurred, and there was some supraorbital neuralgia. She was anæmic, but said she enjoyed her usual health. Her appetite was good, and she was able to do her housework, although the eye pained her at times and she could not see well with it. As a tonic she was given a mixture of iron and quinine, atropine was instilled into the eye, and calomel was dusted on the cornea.

For the first two days the eye improved, but on the third day it was worse. The calomel was omitted, believing that it irritated the eye too much. But the eye grew worse ; vision was reduced to counting fingers ; the keratitis was becoming profound ; the epithelial layer necrosed extensively ; the supraorbital pain increased, as did also the chemosis and intra-ocular tension. On the evening of the sixth day she broke down completely, saying the pain in her eye would craze her. I thought probably that the atropine was irritating the conjunctiva, and concluded to try duboisine, and give antipyrin for the neuralgia ; but before prescribing these concluded to examine her constitutional condition, when, to my surprise, her temperature was 103° and her pulse 108, and for the first time learned that there was periodicity in the eye symptoms.

Believing the trouble was malarial the eye treatment was stopped, except the use of a mild cocaine ointment, and she was given twelve grains of quinine instanter, and six grains every two hours until twenty-four grains were taken. She had a fairly good night's rest, but was much weaker next day. Six grains of quinine were taken every four hours until the third day, before there was marked cinchonism. Three six-grain doses were given for two days, then twice a day for three days more, when its use was discontinued.

The eye improved from the time the quinine began to affect the system, and got well by its continued use.—J. E. M. in *Kansas Med. Jour.*, March, 1890.

Hansell (H. F.) on Abscess of the Cornea.—The patient was an emaciated, delicate woman of thirty, completely exhausted from nursing a fifteen months' old baby. This exhaustion was in all probability the cause of the disease. She was too weak to leave her room, and so discouraged that she feared each day would be her last. The abscess was situated on the lower inner quadrant of the cornea, measured about four millimetres in diameter, and involved all the layers of the cornea except the deepest. The epithelial surface was elevated by the pus. Hypopyon and unguis, neighboring cornea clear ; iris dilated, but not adherent. The patient had been under treatment at a dispensary for two weeks before my first visit, and was using a solution of cocaine, atropine, and boracic acid locally, and iron and quinine internally. She had but little pain, and no photophobia. Vision for large objects only.

The abscess was opened and scraped on two successive days, the knife passing through diseased tissue only. Instillations of eserine every three hours by day, and atropine twice during the night ; washing with Panas' fluid and frequent hot-water bathing were ordered. The baby was weaned, and the patient given twelve grains of quinine daily, with milk-punches and nourishing diet. In three weeks all inflammatory symptoms had subsided, leaving a thick white cicatrix three millimetres in diameter, without adhesions of the iris.

The writer protests against the common practice of prescribing cocaine in abscess and other severe corneal affections. As a remedy, cocaine has no place in the thera-

peutics of the cornea. It is deservedly held in high esteem as an anæsthetic for the surface of the eye, and as an aid to atropine and other mydriatics in dilating the pupil. It is a well-known fact that it destroys the anterior epithelial surface of the cornea, and this occurs when used in weak as well as strong solutions. If applied but a few times, the epithelium is afterward restored, and the eye suffers no damage. If, however, the applications are frequently repeated, superficial ulcers and opacities result. The momentary relief from photophobia or pain cannot be advanced as a sufficient reason for its use in face of the undeniable fact that this very relief is obtained at the expense of the membrane already diseased. It needs no argument to prove how pernicious this action must be in those diseases which are caused by loss of epithelium and destruction of underlying tissue.—*Med. News*, March 8, 1890.

Hodges on Keratitis Subepithelialis.—It had been observed to follow acute catarrh, and was especially noticed after influenza, and was most prevalent between December and March. The first symptom was a copious secretion, resembling tears, and neither mucous nor purulent. After this might be seen numerous, twenty to thirty, fine white dots occupying the centre of the cornea. A patient was exhibited who was seen in the third week of December, when he presented the above appearances. V = $\frac{6}{18}$, disc looked hazy. He was treated with atropine and mercury, but an unfavorable prognosis was given. On December 24th, one week later, V = $\frac{6}{9}$. On December 30th, Vn. ; he subsequently took iron and strychnine ; one eye only was affected. The patient was now quite well, but faint traces of the affection could still be seen in the cornea.—*Brit. Med. Jour.*, March 8, 1890.

Morrison (F. A.) on the Artificial Attachment of a Detached Iris.—In a woman of fifty while undergoing a cataract operation by the von Graefe method a sudden movement of the eye detached a considerable portion of the iris at its ciliary border, but the condition was not manifest for several days after the operation.

An examination, Feb. 12, 1890, disclosed the following condition of the eye.

About one fourth of the iris had been torn loose at its periphery and, falling across the pupil, attached itself to the pupillary margin of the opposite side and completely occluded this opening.

Dreading the effect of the removal of so large a segment in addition to what had already been taken away, the following plan was devised and put into execution : With assistance a paracentesis needle was entered at a point upon the sclerotic just behind its junction with the cornea, where it was estimated that the angle formed by the union of the line of rupture with the detached ciliary border of the iris would come in contact with the sclerotic, if the parts were in their normal position. The needle was then carried obliquely through the sclerotic into the anterior chamber and was caused to enlarge the wound slightly in its withdrawal. Very little of the aqueous humor escaped. Now gently passing a Desmarres' cystotome into the wound and across the anterior chamber, its cutting edge was used to divide the adhesions between the contiguous margins of the iris; this done the latter floated freely in the aqueous humor. Withdrawing the cystotome, a sharp Tyrell's hook was pushed carefully along the posterior surface of the iris and made to seize it at the angle formed by the rent and the detached ciliary margin, and this angle was drawn carefully into the sclerotic incision and there left, held securely by the approximation of the walls of the valve-like slit. The immediate effect was a complete restoration of the pupil to its proper shape, accompanied, of course, by an immense increase in the volume of light entering the eye. Very little reaction followed, and in the course of a few hours the iris was firmly fixed in its new locality.—*Weekly Med. Rev., March* 8, 1890.

Berry on a Case of Spontaneous Purulent Hyalitis Nine Months after Successful Cataract Extraction.—The patient, aged fifty-three, a glass-blower by trade, was operated on for cataract of the left eye on March 19, 1889. Every thing went well, and he left the hospital on the eleventh day, the wound being then soundly healed. Vision with + 11 D was $\frac{6}{6}$. Patient resumed work a month later. On December 20th he was readmitted with intense pain in, and almost complete loss of vision of, the left eye. He had left work at 4 P. M. the previous day, and was reading until 9 P. M. At midnight he was awakened with severe pain in the globe, and on presenting himself twelve hours later there

was acute purulent iritis with hypopyon; T + and vision reduced to counting fingers with difficulty. No improvement took place, and the eye was enucleated on January 2, 1890. Immediate examination of the eyeball showed extensive purulent infiltration of the vitreous, with abundant hemorrhages in the retina, the choroid being to all appearance healthy. Microscopic sections showed that there had been accurate apposition of the lips of the corneal wound. The iris was nowhere adherent to the cicatrix, but there was a slight flat attachment to the cornea in front of it. The suppuration appeared to have commenced behind the margin of the cornea, where a few cocci were found scattered among the cells. The choroid and deeper layers of the retina appeared healthy. The possibility of a sudden violent septic hyalitis taking place spontaneously so long after the extraction was new to the author, and the case was all the more astonishing in that, not only with respect to the acuity of vision, but also from an operative point of view, it had been completely satisfactory. A somewhat similar case had occurred in Dr. Argyll Robertson's practice. Nearly eleven months after a successful cataract extraction the eye had to be removed for suppurative panophthalmitis. This case further resembled the writer's in that the patient was exposed to great heat. The sudden onset and malignant nature of the inflammation left no doubt that it was the result of septic infection; but as it was quite impossible that micro-organisms introduced at the operation could retain their vitality so long without showing signs of activity, there must have been some recent inoculation of the cicatricial tissue. This explanation was that adopted by Mr. Swanzy, who in 1871 published three cases in which peripheral prolapse of the iris had been followed after a prolonged interval by a spontaneous and incontrollable purulent iridocyclitis. The presence of micro-organisms in such cases was demonstrated by Leber in an article in *Graefe's Archiv*, 1878, on "The Intercellular Spaces of the Corneal Epithelium." He stated that the bursting of an attenuated portion of a peripheral anterior synechia took place either spontaneously or as the result of a trifling lesion, and infection began at this point. Dr. Berry had lately been able to confirm this supposition by the discovery of micrococci in the vitreous in a case in which purulent hyalitis took place a long time after a perfectly normal iridectomy for glaucoma simplex. Mr. Priestley Smith had recorded a case of purulent hyalitis occurring spontaneously in the eye two years after cataract extraction. In this case there had been a slight encleisis of the iris. In one mentioned by Arlt there was a prolapse of iris the size of a pea incorporated in a cystoid cicatrix, from which, after fifteen years, a sudden panophthalmitis originated.—*Brit. Med. Four.*, March 22, 1890.

Eye Enucleated by a Stream of Water from a Fire-Engine.—In this interesting case, narrated by Dr. Thomas F. Wood, in the *North Carolina Medical Journal*, March, 1890, the eye was enucleated as neatly as though it had been done by the surgeon's scissors. The optic nerve must have been ruptured about the commissure, judging from the length of that part remaining attached to the ball. The patient stated that he was about five feet from the nozzle when the accident occurred. He was a negro fireman, and he was acting as pipeman during the progress of a fire. He suffered no pain, and when he presented himself the eye was hanging on the cheek, held by a portion of the internal rectus muscle. One sweep of the scissors completed the work of the stream of water, and the patient, on asking the doctor what he was doing, and being told he had taken his eye out, asked: "Well, ain't you goin' to put it back again?"

The surrounding integument was entirely uninjured, and the patient recovered without an untoward symptom.

Cotter (R. O.) on a Case of Almost Total Destruction of the Iris; Recovery with Perfect Vision.—A farmer, aged 36, was struck late last June in the right eye by a sharp, flat piece of flint rock. He suffered intensely, and on July 1st he came to me for treatment. I found that the piece of rock had penetrated the cornea close to the iris, at the temporal side. It was so large as to almost completely fill up the upper half of the anterior chamber, and was firmly imbedded and adherent to the iris. Although I freely used a 10-per-cent. solution of cocaine, it made hardly any impression upon the pain of the operation.

The corneo-sclerotic junction was incised with a cataract knife, just as if for a cataract extraction, and the iris was found

to be so bruised, lacerated, and involved in the wound from the foreign body that I had to remove fully three fourths of the iris in order to extract the piece of rock. There seemed hardly any prospect of vision to be secured, and my idea was to give him relief from the pain, and prevent, if possible, total destruction of the ball. The ragged edges of the wounded iris were carefully trimmed, a 2-grain solution of atropia was directed to be used in the eye for a few days, warm-water applications to the eye advised, and the patient sent home.

To-day (February 13th) he was in town and called on me. I was greatly surprised at his assertion that he could see with the eye as well as he ever could. The eye had healed entirely. He has only a narrow strip of iris in the lower segment. I tested his vision and accommodation carefully. His vision is perfectly normal, being 20-20. He reads Jaeger No. 1 type (the very smallest), at the usual reading distance, with ease.—*Southern Med. Record*, April, 1890.

Tiffany (F. B.) on a High Degree of Hypermetropia.—A man of twenty-five, gray eyes, consulted me February 21, 1890. Examination revealed one of the highest degrees of hypermetropia I have ever seen. The optic nerve and retina, with their blood-vessels, could be easily seen without a mydriatic at a distance of four or five feet from the eye. The antero-posterior axes of the ball measured less than 20 mm., while the greater diameter of the optic disc measured less than 5 mm. There was a slight physiological cupping of each disc. Vision of the right eye was $\frac{20}{120}$; vision of the left, $\frac{20}{120}$. With a plus 8 D, the vision of either eye was brought up to $\frac{20}{20}$. There was convergent strabismus of both eyes; 6 mm. of the right and 4 mm. of the left. I prescribed the strong glasses of plus 8 D, which the patient is wearing with satisfaction and comfort. With them he is able to read the finest print. They have entirely relieved him of the ciliary neuralgia, or temporary headache, of which he complained and for which he mainly consulted me. The strabismus by the use of the glasses is also being corrected. The main points of interest in the case, as it appears to me, are the extremely high degree of hypermetropia, the alternating concomitant squint, same amount of vision in either eye, the extreme shortness of the eyeball, the small disc, and the tolerance of so strong a convex glass.—*Denver Med. Times*, March, 1890.

Roosa (D. B. St. J.) on the Relation of Errors of Refraction and Insufficiency of the Ocular Muscles to Functional Diseases of the Nervous System.—The conclusions to which the author has come, as a result of twenty-six years of work in ophthalmology, with a careful consideration of the writings and works of others, including those who believe that functional nervous disease is due to the eye "more than to all other causes combined," are as follows:

First. The eyeball of the human race is very rarely in what might be defined as an emmetropic condition.

Second. Perfect equilibrium of the ocular muscles is by no means a common condition, even among persons of sound health and without asthenopia.

Third. Defects in these two states by no means necessarily produce even local disturbances, such as are comprehended under the term of asthenopia, inflammation of the edges of the lids, and so forth, although high degrees of hypermetropia, moderate degrees of astigmatism, and all cases of mixed astigmatism are apt to do so, sooner or later.

Fourth. Asthenopia depends chiefly upon two sets of causes—nervous exhaustion and uncorrected errors of refraction.

Fifth. In estimating the influence of these defects great stress should be laid upon the general condition, and the line sharply drawn between asthenopia due to exhaustion and that to faulty refraction.

Sixth. Nothing has been added essentially to Donders' discovery of the fundamental cause of accommodative asthenopia, except that astigmatism forms a more important factor in its etiology, muscular asthenopia falls into the background, while the definition of asthenopia has been much amplified by ophthalmologists.

Seventh. The origin of a considerable class of such diseases as chorea, epilepsy, and hystero-epilepsy has not been found in errors of refraction nor in insufficiencies of the muscles of the eyeball.

The observing general practitioner of our city is able to test the truth of this latter proposition as he looks among the neurotic families and individuals of his acquaintance, and observes whether or not the use of glasses and the performance of ocular tenotomies are beginning to lessen

the cases of chorea and epilepsy. Certainly a discovery which it was predicted would vie with those of Jenner and Lister has been proclaimed with sufficient fulness and clearness, and has been acted upon in an arena large enough to allow us by this time to judge whether or not it is an advance in rational and scientific therapeutics. The author does not believe that it is, but he believes that the theory of the ocular origin of nervous disease, by distracting attention from the evident, and in some instances preventable, causes of neuroses, has delayed our progress and inflicted serious damage to the reputation of our profession for accurate observation and philosophical conclusions.—*Med. Record*, April 19, 1890.

MISCELLANY.

Hood (D. W. C.) on a Case of Chronic Nasal and Pharyngeal Catarrh Apparently Caused by Using a Hair-Wash Containing Arsenic.—On July 22, 1889, A. B——, a gentleman aged forty-two, consulted me for a "cold in the head," which he told me had been more or less constant since the previous March. There were no other symptoms of illness; the chest was healthy, and the urine to ordinary tests perfectly normal, the symptoms being solely those of a heavy "cold in the head." The catarrh was worse in the morning, and was then accompanied with a little cough; the throat was not sore, but complained of as being uncomfortable. The mucous membrane looked injected, and perhaps a little swollen. There was nothing in the nares to account for the symptoms. The patient had been a good deal harassed by the management of a large business, and had had no proper holiday for some time. I thought the cold or succession of colds might result from this, so suggested a thorough change, to commence with a few weeks at the seaside. At the end of August I heard again from A. B——. He wrote to me, stating that since consulting me in July he had been to the seaside and Scotland, having been away from town nearly two months. He felt perfectly well, but the cold in the head was as bad, if not worse, than at the time of seeing me in July. Immediately on reading this letter, my suspicions as to arsenic being the exciting cause were aroused. It was evident that if arsenic was producing this constant catarrh, it was not to be looked for in the London house, but was to be sought for in something of frequent if not daily use. On making inquiry, I ascertained that early in the preceding March the patient, suffering from premature baldness, had consulted a "hair doctor," and had been given a lotion or hair-wash, which had been used daily up to this date (August). The lotion was applied to the skin of the scalp, and allowed to dry on. The catarrhal symptoms commenced about a fortnight after first using the wash, and had remained without any intermission up to the end of August. This lotion was examined, and found to be heavily charged with arsenic. Within a few days of leaving off this pernicious application the symptoms (catarrh) began to abate, gradually ceased, and have not again returned. It is worthy of notice that in this case, if the symptoms were produced by arsenic, and of this I think there can be little doubt, the poison was absorbed from an unbroken skin, and caused no irritation of skin, stomach, or bowel.—*Lancet*, March 15, 1890.

Cary (W. L.) a Criticism on the Weigert Hot-Air Treatment of Pulmonary Tuberculosis.—The conclusions arrived at by the author are as follows:

I. Comparative pathology and the natural history of pulmonary tuberculosis in man indicate that the most favorable temperature for the *intra-pulmonary* development of its bacillus is much higher than 99.5° F.

II. Tubercular bacilli, in a favorable soil within an animal organism, are not attenuated nor their development arrested by temperatures which are inimical to them in artificial or non-vitalized culture-media, but even rendered more virulent and more rapidly reproductive.

III. Temperatures demanded for effective disinfection or discontinuous sterilization by dry heat are impracticable and injurious to the animal organism.

IV. It would appear that Dr. Weigert is mistaken in supposing that the residual air is heated much above 113° F.; and that, in fact, there is but very slight, if any, elevation of the intra-pulmonary temperature. Recent advices from Germany inform us that accurate measurement of the actual elevation of the lung temperature is but ½–1° F.

V. If it were possible to produce and maintain, even for a short time, an intra-pulmonary temperature approaching 113°, there would be produced, independent of the effect upon the lung-tissue, grave degenerative changes in the blood and entire cellular elements of the body.

VI. At temperatures far short of those claimed, there would be produced an auto-infection and accumulation of excrementitious products, by diminished respiratory capacity, directly deleterious to the organism at large, and indirectly embarrassing to those nutritive activities upon whose integrity all hope of permanent benefit to the consumptive must rest.

VII. The factor productive of the benefit arising from the Weigert method is the *dryness*, rather than the heat, of the inspired air; and this desiccating action cannot be obtained except the temperature of the inspired air be as low at the upper as in the deeper parts of the lung. Of further benefit are pulmonary gymnastics, the psychological effect, and possibly in some cases a favorable action upon the bacteria in the larger bronchi. — *Brooklyn Med. Jour.*, April, 1890.

Chloride of Orexin as a Pure Stomachic.—Professor Penzoldt of Erlangen, after a series of observations made both on healthy medical students and on patients suffering from various affections accompanied by want of appetite, thinks himself warranted in recommending a complex chemical substance, the correct systematic name of which is "chloride of phenyl-dihydro-chinazolin," but for which he proposes the simpler name "chloride of orexin," from ὄρεξις, appetite. He found, by examining the contents of the stomach by means of the œsophageal tube, that in the healthy subjects bread and meat were always digested from half to three-quarters of an hour sooner when chloride of orexin was taken than under ordinary circumstances. Observations were subsequently made on thirty-six patients who suffered from anorexia. In five there was no effect, in five more it was of a doubtful character, but in all the remaining twenty-six cases, a marked effect, and in some a surprising one, was produced. This occurred in some instances after the first few doses, but in others the treatment had to be continued for several days before its effects began to show themselves, but these were mostly cases of long standing. The class of cases in which orexin proved most useful were those where the stomach was not diseased, but where the loss of appetite was due to some general condition, such as anæmia, phthisis, or weakness following an operation. Very rarely unpleasant effects were complained of, as a burning sensation in the œsophagus during the deglutition of the orexin, or occasionally vomiting. No effect was observed in the pyrexia of phthisis. The dose ordered was generally from five to seven grains in from three to five pills, and this quantity was given once or twice a day, a cupful of beef-tea or broth being taken with each dose, on account of the pungent properties of this compound. If no effect is produced in four or five days, the treatment should be intermitted for a few days.—*Lancet*, March 29, 1890.

Elder (T. A.) on Sodium Sulphite in the Treatment of Scarlatina.—The author gives from gr. v. to xx. of the sulphite of sodium every hour in scarlatina, with, he claims, the best possible results.

The epidemic, in which he experimented, would be termed a mild one from the fact that no deaths occurred. And yet two cases might be characterized as severe, one quite severe, and two as very bad ones.

There were a number of other cases in the neighborhood, mostly milder, which were treated with the sulphite alone, and in which the patients got well in three or four days.

The sulphite seems to have aborted some of the cases.

The sulphite seems to shorten the duration of all cases, and to relieve them of dangerous sequelæ.

In none of these cases was there nephritis, nor subsequent œdema of the feet or legs, that would indicate any affection of the kidneys.

The sulphites seem to operate in such a manner as to save the life of the cuticle. There was very little desquamation, and that almost entirely confined to the thick skin on the ends of the fingers and toes.

The sulphite acts as an irritant to the bowels in some cases, producing diarrhœa. In such cases its effect on the fever is not so manifest, and yet it has a beneficial action.

Rapid and safe convalescence seems to follow the use of the sulphite in every case.

These cases were not all uncomplicated cases, nor was the sulphite of sodium alone used in all the cases.—*N. Y. Med. Jour.*, March 29, 1890.

THE MEDICAL ANALECTIC AND EPITOME.

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE.

EDITED BY R. W. AMIDON, M.D.

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REPORT ON OBSTETRICS AND DISEASES OF CHILDREN.

ELIZABETH STOW BROWN, M D.

Blume (F.) on the Etiology and Treatment of Placental Retention Due to Constriction of the Contraction-Ring.—The pregnant and parturient uterus consists of three parts, which differ essentially in their anatomical structures and physiological functions: the upper and the lower uterine segment, and the cervix. The lower uterine segment is that portion of the uterine body which extends from the internal os to the point of peritoneal insertion. Originating at an early period of gestation, developing during pregnancy, it is thinned out during labor, and forms, with the distended cervix and vagina, a large flaccid sac, through which the child and the placenta are driven.

The boundary line between the contractile upper segment of the uterus and the lower uterine segment is designated by Schroeder the contraction-ring.

After the expulsion of the child, the placenta, if not interfered with, is separated and expelled through the contraction-ring by the efforts of nature in an average time of fifteen minutes. By the descent of the placenta, the collapsed lower uterine segment becomes distended, the contractile part of the uterus is pushed upward, and the fundus rises from two to three inches. The detachment of the placenta, and its expulsion through the contraction-ring, if left to the powers of nature, ensues so regularly that its retention is a rare occurrence. While a true adherent placenta, even the existence of which is questioned by some authors, is doubtless not frequently met with, the third stage of labor is oftener complicated by the incarceration of the afterbirth, caused by the constriction of the contraction-ring.

The writer then relates the histories of three cases which have come under his operation. Analyzing these cases, and considering in the first place the nature of this anomaly, the author finds that the condition is not a stricture in the usual sense of the word. It is not a circular contraction of a single portion of the uterus, which complicated the third stage of labor, it is a spasmodic action of the entire upper uterine segment, which, without intermissions, remains in a condition of almost permanent contraction.

The most potent factor to produce this contraction was, in the author's cases, the early discharge of the amniotic fluid. Its stimulating influence upon the uterine focus is well known.

The delivery of the imprisoned placenta, dilatation of the contraction-ring should be effected with great care and without undue force. The constriction usually yields to the carefully dilating finger, while pressure from above, through the abdominal wall, is fruitless. Should the resistance be too great, the patient is to be chloroformed, and another attempt may be successful. If all efforts to deliver the placenta should fail, and danger from sepsis be imminent, Porro's operation remains as a last resource. —*Pittsburg Med. Rev.*, Feb., 1890.

Porak—De la Chloroformization dans le Cours de l'Accouchement Normal. (On the Use of Chloroform in the Course of Normal Labor).—The author has studied the laws of the

passage of chloroform through the placenta. He has found that even when the mother absorbs great quantities of chloroform, very little passes through the placenta. The fœtus, not being able to eliminate this agent by the lungs, casts it off by the urine. The chloroform accumulates in the brain, existing only in very small doses in the blood, not to be recognized chemically. The existence of these very small doses of chloroform in the fœtal organism has no serious influence upon the health of the new-born. So then, to the author's mind, the danger to the child does not furnish a contra-indication to the obstetrical use of chloroform.

Chloroform causes the parturient contractions to come at longer intervals; but ought not to render the forceps more frequent. The author resents this common charge against chloroform, and adds that it is not the chloroform which is at fault, but the accoucheur who lacks patience.

The last reproach against chloroform is that it produces hemorrhage. The author has not seen serious hemorrhages under its use, but admits that the post-partum flow of blood is a little more free than usual. So he believes that it is prudent not to employ chloroform with women who are subject to loss of blood after their confinements. He employs a hypodermic injection of ergotine to ward off or moderate possible hemorrhage.

Obstetrical chloroformization is distinguished from surgical chloroformization in two particulars. The period of excitation is notably modified, and the usual exhaustion that follows its surgical use does not exist in labor.

In conclusion, chloroformization in small doses and intermittently during confinement is a marvellous sedative of general troubles. If it is an inconstant analgesic, it produces sleep, sometimes the suppression, at least the shortening, of the pain which accompanies uterine contraction, notable diminution of consciousness, and often the absolute suspension of memory. Its action is also variable, according to the power of reaction of the subject, and the nature of the agent, and its mode of administration. Its inconveniences are inconsiderable in the face of its advantages. —*Rev. Obstet. et Gyn.*, Paris, March, 1890.

Redfern (John J.) on Interstitial Emphysema in Parturition.—The patient was a well-developed primipara of 26. After the beginning of the second stage, the head became engaged in the rim, and labor proceeded slowly. After the membranes were ruptured the pains succeeded each other at intervals of a few minutes, and were much stronger, the patient holding her breath, and bringing the accessory muscles of respiration into action. After a time the patient complained of a sore feeling in the throat, and for this she was given warm drinks. She had no vomiting. Shortly afterwards the right eye was noticed to be puffed, and this puffiness extended to the right side of the face so as to obscure the usual facial landmarks. By this time the patient showed signs of great exhaustion, though no special attention was directed to the respiration. The puffiness and exhaustion becoming more and more marked, forceps were applied without chloroform, and the labor was terminated shortly afterward. The patient now complained of swelling of the right eye, the face, and neck, and of a "sore feeling" over the upper half of the chest. She was distinctly hoarse. The tissues round the right eye were much swollen, and on pressure gave the crackling characteristic of emphysema. Her left eye was less affected. Her face (including both cheeks and the forehead), the anterior and antero-lateral aspects of the neck (extending backwards as far as the posterior margin of the sterno-mastoid muscle), as well as the anterior surface of the thorax (as far laterally as the axillary line, and inferiorly as the mammæ), were swollen considerably. They pitted slightly on digital pressure, and gave the characteristic emphysematous crackle. The patient passed a restless night, and in the morning renewed her complaint of soreness on the chest and neck. She was ordered to have the affected parts rubbed with oil. Twenty-four hours later she felt much better, and from this time made an uninterrupted recovery.

Some abrasion of the mucous membrane of the trachea or larynx, or bursting of pulmonary air vesicles most probably gave admittance to the air in this instance. The hoarseness and soreness of the throat, which were both marked, seem to favor the former alternation. It is noteworthy that the loose subcutaneous tissue about the orbits and neck was the first to suffer, and that in this case there were no respiratory symptoms.

Consideration of the recorded cases

teaches that (1) emphysema in parturition is rare, and is usually of no great importance when limited in extent; (2) that it spreads rapidly unless the labor is completed, and that then the prognosis becomes grave; (3) that labor should therefore be terminated by instrumental means as soon as possible; (4) that when the excessive muscular exertion ceases the emphysema gradually subsides by the absorption of the air.—*Lancet*, Feb. 15, 1890.

Grandin (Egbert H.) on Ectopic Gestation. Electricity *vs.* Primary Laparotomy.—By fairly uniform consensus the methods which aim at destruction of the ovum through puncture of or injection into the sac are considered both dangerous and unsurgical, and there are left for consideration the resort to electricity and primary laparotomy. The advocates of electricity claim that it is efficient and fraught with no immediate risk if applied within the proper limitations; whilst those who favor primary laparotomy insist, with equal fervor, on the one hand, that electricity is valueless, and on the other hand, that even if effective, it is illogical to leave an object within the abdomen, which, through suppuration, must eventually endanger the life of the woman.

The position of those who advocate electricity may, in all fairness, be summarized as follows:

1. The ovum may be destroyed by electricity, the constant or galvanic current being employed.

2. Electricity, resorted to prior to the third month of gestation, and in the absence of symptoms pointing to rupture, carries with it no immediate risk, and the chances of future danger are insignificant.

An argument which has been advanced in favor of primary laparotomy is that, generally, the diagnosis of ectopic gestation is only certified to on opening the abdomen, and that resort to the knife is indicated for relief of an obscure condition, that is to say, the laparotomy is exploratory. But under the limitations for resort to electricity, as held by the writer, the symptoms are not urgent; there are no signs of impending rupture. Electricity, as has been proved over and over again, can do no harm, and if the diagnosis be correct, will kill the ovum. After the third month, when ossification has advanced to a considerable degree, primary laparotomy should be the choice, chiefly for the reason that the chances of absorption are lessened by the presence of bone.—*The Times and Register*, Feb. 22, 1890.

Heinricius (G.) on Carcinoma of the Neck of the Uterus Complicating Pregnancy and Labor.—The patient, at the time of her application for admission to the hospital, was forty years old, had been married twelve years, and had had seven children. For eight months she had complained of leucorrhœa and constant pains in the abdomen. Examination showed the neck of the uterus to be irregular, hard and resisting, and presenting clearly an infiltration of the same nature as that which could be felt in the anterior lip, and which extended into the cavity of the cervix as far as the finger could reach. The anterior lip was rounded, somewhat irregular, as large as a pullet's egg, but not ulcerated. The posterior lip was swollen and friable, but did not appear to be infiltrated. The patient had a normal labor and was delivered of a living child. There was no hemorrhage or other complication during or after labor. Two months after her confinement the patient was entered under the gynæcological service of the hospital. Examination now showed that on the right side of the upper part of the uterus was a hard, movable tumor as large as a walnut attached to the uterus by a ligamenatous cord. On the left side, lower down, was a second tumor, hard and irregular. The posterior lip of the cervix was irregular and rugose, the anterior lip presents a hard tumor as large as a walnut. The uterus was movable and anteflexed. The inguinal glands were engorged, and the patient pale and emaciated. The secretions were not fœtid. While the patient was under chloroform the ablation of the tumor was performed with Paquelin's cautery and the infiltrated portion of the posterior lip was removed. Microscopical examination of the tumor showed its cancerous nature.

The patient continued very feeble. Six months later she was seized with violent convulsions, and remained unconscious until her death, seven days later.

The question presents itself in regard to cancer of the uterus, whether it is possible and necessary to treat the cancer actively during pregnancy. The author thinks that in the presence of a disease which will certainly prove fatal to the mother at some time not very far off, the first thought

should be of the safety of the child. Operations performed upon the genital organs during pregnancy often result in the interruption of pregnancy, and on the other hand, cancer confined to one lip very often gives results favorable to both mother and child. The writer feels sure that the wisest treatment is the expectant plan during pregnancy and an operation only after delivery. The operation delayed but did not prevent death.—*Atlanta Med. and Surg. Jour.*, Jan., 1890.

Draper (F. W.) on the Legal Relations of Obstetrics.—With the exception of surgery, there is no branch of medical science whose legal relations are as important as those of obstetrics; indeed, it might almost be said that obstetrics ranks higher than surgery in the legal scale, not giving rise, perhaps, to as many actions at law, but raising more nice points for legal settlement, and involving in every case the rights and safety of two individuals where surgical actions concern but one.

Once in actual attendance upon a case of midwifery the physician becomes responsible for the safety of mother and child, and if any thing happens it is for him to show that he exercised ordinary care and diligence, was possessed of a reasonable amount of skill in his calling, and used his best judgment in the management of the case. The law makes a great point of the matter of attention on the part of the attending physician. This is a fact that medical men often forget, and it is in obstetrical cases that they are particularly liable to make errors in this direction. The busy practitioner, called to a woman in the earliest stage of labor, does not hesitate to leave her for an hour at a time while he goes off to attend to his other patients. He comes and goes as long as he dares, and not infrequently calculates too closely, finding his patient delivered during his absence when he returns for the last time. If all goes well his absence is easily pardoned, but suppose the woman dies of post-partum hemorrhage before his arrival, the child dies asphyxiated, or the mother suffers from the effects of a lacerated perineum which a primary operation fails to restore, will he not find some difficulty in showing that his absence at the critical point of the labor was justifiable? An old professor of midwifery used to tell how he was one night called to attend three women in confinement, and how, in his endeavor to distribute his attentions impartially, he missed all three of the deliveries. No doubt he thought he was doing his duty to the best of his ability, but had either of the labors resulted unfortunately and he been sued for damages, would the jury have been convinced that there had been no lack of attention on his part and have brought in a verdict accordingly?

The introduction of the use of antiseptics into the practice of midwifery is likely any day to lead to lawsuits, in which the defendant practitioner will be called upon to show either that he took full antiseptic precautions, or that these precautions are not necessary to the safety of a lying-in woman. To be sure the prosecution will first have to prove that antiseptics are necessary, but this will not be a difficult task if they find many ready to take the position of a leading obstetrician of Boston, who in an address before a country medical society intimated that in his opinion the man who neglected to take the fullest antiseptic precautions known to science in attending a case of confinement, was entirely responsible for whatever septic trouble might follow. When this statement is made in court by a qualified expert it will certainly arouse a lively controversy, and without doubt it will be found that the medical profession is far from taking the position that not to use antiseptics in midwifery constitutes malpractice.

The legal status of craniotomy and other operations which destroy the unborn child is curious and interesting. As long as the child is within the maternal passages it is regarded as part of the mother's body and is not a "person" in the eyes of the law. Hence, to quote Dr. Draper, "it follows that the destruction of the life of the fœtus may be brought about within the womb of the mother by the accoucheur in the operation of craniotomity, or in any other way, and the law finds nothing wrong in the act; the only requirement within the legal purview being that, to avoid the element of felony, the mutilation must be so complete that the child shall die while still unborn; for, if perchance, as has unfortunately happened on rare occasions to obstetricians, the child is delivered and separated from the mother while still exhibiting some signs of life, however feeble, after the head has been crushed, it is a subject of infanticide, excusable killing perhaps,

but in law not to be distinguished, save in its motive, from infant murder under ordinary conditions. The thing to be insisted upon is that the mutilation shall be thorough and lethal beyond a doubt before delivery is attempted; the act and its effects should be wholly upon the fœtal side of the line."

Physicians are often perplexed as to their proper course in attending a woman upon whom a criminal abortion has been attempted or accomplished. Are such cases to be reported, and if so, to whom and when? If the patient dies, the case should be reported to the coroner, but until the death of the patient neither coroner nor medical examiners have any official concern in such matters, although it not unfrequently happens that the cases are reported upon death. Medical men are not informers or detectives, and are not called upon to make known their suspicions, however strong, but if a physician actually knows that a crime has been committed he is not safe in concealing the knowledge. In any case the prudent man will fortify himself with a consultant.—*Boston Med. and Surg. Jour.*, March 5, 1890.

Ashley (Henry) on Some Points in the Pathology of the Paralyses Which Occur during the First Two Years of Life. — There are strongly marked lines of difference between the lesions encountered in the adult brain and in the infant. In the adult, when middle life is well past, we find evidences of retrograde processes which tend to weaken or damage the walls of the arteries, and moreover there are cardiac and kidney lesions which tend to increase the tension of blood in the vessels and lead to cerebral hemorrhage. The infant brain has the advantages of immunity from degenerative changes consequent on wear and tear, and the disadvantages of immaturity; for the vessels of the pia mater are exceedingly delicate, and readily allow of oozing through their walls, while the brain substance is wanting in firmness and easily damaged. Moreover, damage to a brain as yet partially developed is likely to effect greater mischief in the long run by interfering with growth, than the same damage to an already well-developed brain. These differences are certain to influence the lesions which occur. In the infant we have meningeal hemorrhage, meningeal inflammation both of brain and cord, and inflammation of the most vascular spots in the spinal cord; while we miss the large cerebral hemorrages, and the various forms of softening so commonly occurring in the brain of the adult towards the decline of life.

The principal forms of paralysis occurring during the first two years of life are classified under the following heads:

1. Intra-uterine lesions (meningo-encephalitis).
2. Meningeal hemorrhage.
3. Syphilitic arteritis and softening.
4. Acute cerebral paralysis (encephalitis and embolism, etc.).
5. Acute spinal paralysis (anterior poliomyelitis).
6. Peripheral paralysis.—*Br. Med. Jour.*, Feb. 8, 1890.

Blackader (A. D.) on a Case of Ataxia in a Child Twelve Years of Age.—The boy, at the age of two, had a fall, cutting the front of his forehead. Since the age of five he has suffered severely from headaches. When six years old the first distinct symptom of the present illness was noticed as an unsteadiness in his gait, producing occasional falls. This weakness and staggering gait have gradually become worse, until he was brought to the physician at the age of twelve. Two or three years ago his mother first noticed some alteration in his speech, and this has gradually become more marked.

On examination, the boy was found to have distinct talipes equinus in both feet, and slight curvature in the spine. There is a well-marked ataxic gait. In walking the body sways from side to side, the legs are widely separated, and the feet are thrown forward. There is also distinct ataxia in the upper extremities, though much less marked than in the lower. There is complete absence of patellar reflex, but the cutaneous reflexes are only slightly diminished. There is no muscular atrophy, and no spastic rigidity. Speech is distinctly jerky, with an abrupt pause between the several syllables, and occasionally elision of the last consonant. This is much less marked in reading than in speaking. No nocturnal enuresis, but his mother states that he takes longer to pass his urine now than formerly. Intelligence unimpaired.

In this case the symptoms pointed to disease confined almost entirely to the posterior columns, but involving also the medulla. Cerebellar disease would appear to be excluded by the history of the case,

the absence of occipital pain, the absence of optic neuritis, the absence of the patellar reflex, and the presence of the ataxia in the upper extremities.—*Montreal Med. Jour.*, March, 1890.

Caillé (A.) on Two Cases of Nystagmus Associated with Choreic Movements of the Head in Rachitic Babies.—The first case was of a child eleven months old in which the choreic movements were noticed by the mother on the day following an injury to the head by falling from a high chair. The muscles supporting the head were in such a state of unrest as to seriously interfere with the comfort of the child. A careful examination showed a marked rachitic development and nystagmus of the horizontal type. The eyes were examined by competent ophthalmologists, and, excepting nystagmus, nothing abnormal was detected. It was furthermore noticed that if the child's attention was engaged by a shining object held at some distance above the eye-level; nystagmus and choreic movements would cease during fixation. It was also apparent that the movements of the head were not the consequence of muscular weakness, but, on the contrary, it seemed as though they were due to a distinct effort on the part of the child for the purpose of visual fixation, made difficult by the existing nystagmus. The application of an eye-bandage suggested itself, and as soon as this was in such a position as to exclude any ray of light the choreic movements ceased completely; if, however, the bandage was so applied as to admit but very little light, the head movements persisted.

Under such circumstances a permanent eye-bandage suggested itself as a therapeutic procedure. The bandage was properly applied, and removed but once a week for cleansing purposes. The child received salt baths and massage, and took phosphorus. At the end of three months nystagmus and choreiform movements had ceased, and the child was plump and healthy in appearance.

In a second child the symptoms manifested themselves after an attack of measles. At the time of presentation there were moderate conjunctivitis, the nystagmus of the vertical type, and the movement of the head. The treatment and ultimate results were the same as in the first case.

The writer expresses it as his opinion that the localized clonic muscular spasms were either compensatory to the movements of the eyeball or reflex from irritation occasioned by the light to those structures which are concerned in conveying the impression.—*Archives of Pediatrics*, March, 1890.

MEDICINE AND PATHOLOGY.

Kinyoun (J. J.) on Entero-Malarial Fever.—The existence of such a clinical entity as typho-malarial fever has long been hotly affirmed by southern and southwestern observers. What has heretofore depended only on clinical data seems now to have acquired substantial pathological proof. The author, in the Marine Hospital service, has studied cases of illness contracted by seamen from drinking stagnant water in the pine regions of Virginia. In some of these cases malarial, in others enteric, symptoms predominate.

A brief synopsis of the symptoms of one case will serve for both:

H. M., aged twenty-three, was taken sick two days before admission, the attack commencing with a chill followed by fever, marked by a remission. On the day of his admission he had chilly sensations, then a rise in temperature, followed later by remission. A careful physical examination revealed nothing abnormal, except a slight tenderness of the epigastric region and a considerable enlargement of the spleen. The bowels were constipated. A microscopical examination of the blood was made, and a large number of the *Plasmodia malariæ* were found free both in the serum and within the blood-corpuscle. This established the diagnosis of malarial fever of the remittent type.

On the fifth day after admission there appeared on his abdomen several suspicious-looking spots suggestive of enteric complications. On the day following he had slight epistaxis, a tendency to diarrhœa, and tenderness in the right iliac fossa. At this juncture a bacteriological examination was made of the fæces, and after several trials a bacillus answering to the description of that described by Eberth was isolated from the stools.

An examination of the blood at this time demonstrated the presence of the malarial parasite, but in greatly diminished numbers, being confined to the corpuscle.

During the next week the enteric symptoms became so marked that without any microscopical examination there could be no doubt concerning the enteric fever. At this time the remissions had ceased, and the temperature curve was characteristic.

In the second group of cases (three in number) the enteric symptoms were well marked, giving a clear history of the disease. The patients had just returned from the South, where malaria was rife. The history gave the prodromal period, lassitude, etc., followed by diarrhœa, epistaxis, and tympanites, and in one case slight hemorrhage.

As a matter of routine the blood was examined for the parasite, which was found confined to the corpuscle not free in the blood serum.

A bacteriological examination was made in each case, and the bacillus of enteric fever isolated, thus establishing the coexistence of both factors in the disease.

The author concludes :

1. That malarial and enteric fevers are not antagonistic to each other.

2. That a differential diagnosis between the two diseases is sometimes impossible.

3. That there exists a mixed form of infection, which can be diagnosticated by means of a bacteriological and microscopical examination.—*N. Y. Med. Jour.*, April 26, 1890.

Hysterical Symptoms Following Typhoid Fever and Influenza.—Professor Grassey, of Montpelier, has recently recorded a well-marked instance of this condition occurring in a girl twenty-three years of age, who until then had shown no signs of hysteria. She had passed through a mild attack of typhoid fever, and was convalescent, and allowed to get up daily, when she was suddenly attacked with complete paraplegia. This was considered to be "hysterical" in character because of the coexistence of the following symptoms : a number of persistent stigmata, incomplete left hemianæsthesia, absence of the pharyngeal reflex, and contraction of both fields of vision. A month later complete aphonia was developed. The diagnosis of hysteria was verified a few days later by the patient suddenly recovering her voice and the power over her legs, so that in a few days she was able to leave the hospital in perfect health. A similar case is quoted from Trousseau. A patient of his, twelve years old, was attacked with paraplegia during convalescence from typhoid fever, and all treatment was without benefit, until one day she was accidentally locked in her bedroom. When the nurse returned she found the patient standing at the door, having walked without much difficulty from her bed to try to open it. In neither of these cases had there previously been any tendency to hysteria.

The same author and Ranzier record an interesting case in which curious nervous symptoms followed an attack of *la grippe*. The patient was a soldier, twenty-eight years of age, who had previously been a farm laborer, and had enjoyed good health, with the exception of frequent cramps of both arms and legs. When attacked by influenza he was admitted to the military hospital, and on the second day had a fit in which arms and legs were acutely flexed. The fit lasted half an hour ; he did not lose consciousness, but he passed urine involuntarily during the fit. Afterwards there was temporary right hemianæsthesia. This soon passed off, except as regards the right arm. Movements at the shoulder and elbow were perfectly normal, but movements of the wrists and fingers could not be performed, and passive movements were painful. Tactile sensation was unimpaired, but there was analgesia from the wrist to the finger tips, which terminated abruptly just above the wrist. There was also abolition of the pharyngeal reflex. Up to the time of publication no alteration had taken place in the symptoms. The authors regard the case as simply one of hysteria in the male induced by the onset of the influenza.—*Lancet*, April 26, 1890.

Klophel (C. G.) on Urinary, Urethral, Catheter, or Urine Fever.—The author gives details of a case in his practice and then summarizes his ideas on the subject as follows :

1. In operations for the relief and cure of chronic retention of urine, the complete evacuation of all the urine at first should not be permitted, but rather the withdrawal of only a few ounces, and the immediate injection of a solution of boracic acid or other mild antiseptic, in volume equal to one half the quantity of urine withdrawn, lessening with each succeeding injection the quantity of fluid thrown in, and increasing the amount of urine withdrawn. Thus, by regular gradation the bladder is emptied, and the circulation, in its abnormal walls, is accommodated by degrees to

the new order of things. The same may be said of the ureters and kidney. As a result, we have less shock, if indeed any; no suppression of urine; no hemorrhage from the urinary organs; and slight, if any, urine fever, so called.

2. Tight strictures of the membranous urethra are more successfully, and hence more safely, dealt with by perineal section. When associated with strictures of the pendulous urethra, the combination of internal and external urethrotomy is undoubtedly the best treatment.

3. The decomposition of blood, urine, and other organic matter in the bladder or urethra may give rise to the phenomena through the production of ptomaines; hence the necessity for antiseptic treatment, generally and locally.

4. The disease is more common among those who are predisposed to it by the nature of a peculiar nervous temperament.

5. In view of the fact that more or less shock attends all urethral operations, especially the forcible and rapid dilatation of old strictures with sounds; and as sudden death has followed even the gentle insertion of a sound, the calibre of which was less than that of the stricture, it is hence important that all practical precautions should be observed in every case of dilatation of a urethral stricture or strictures, with a view to avoiding, so far as possible, such effects, that unhappy sequel being more liable to follow rapid dilatation of old strictures when not preceded by internal urethrotomy.

6. It is also important to ascertain the condition of the bladder, urine, and kidneys before operating for stricture of any degree, and when these two organs are found extensively diseased, the greatest skill, gentleness, and patience are necessarily called for in the treatment of strictures. Further, when these organs are diseased, and we have to deal, in a given case, with several strictures of very small calibre of the pendulous urethra, two courses compatible with safety are presented,—viz., gradual dilatation alone, or internal and external urethrotomy, leaving a few days between the internal and external operation, the latter being done first.

7. Quinine, in any quantity, exerts no manifest influence over the course of the disease.

8. Boracic acid, internally, by its resolvent and antiseptic action, doubtless does exert a favorable influence upon the disease, and will prove a prophylactic if given some days before operating.

9. With a further view to prophylaxis, both before and after all operations upon the urethra,—even simple catheterism,—the canal should be injected with some mild antiseptic. This is more essential after each act of micturition, subsequent to internal urethrotomy.

10. When urine fever persists despite all treatment, or should, after any operative interference with the urethra, jeopardize the patient's life, perineal section should certainly be done.

11. I believe the disease in some instances to be one resulting from the escape of micro-organisms into the circulation. In others it is due to the absorption of their products at the points of operation. It is probable that in some cases the absorption of these products, and those of tissue disintegration, take place at different points throughout the genito-urinary tract. In other words, in some it may be a septicæmia, in others a sapræmia. I think, so far as our knowledge goes, we may have both acting at one time.—*Therap. Gaz.*, March 15, 1890.

Brettner on Expulsion of Necrotic Tissue after Poisoning by Sulphuric Acid.—The necrotic tissue, fourteen centimetres long and twelve wide, had been expelled by vomiting five days after attempted suicide by drinking sulphuric acid. The quantity supposed to be drunk was a quarter of a litre. The vitriol was taken early in the morning, the last food the night before, so that the stomach was empty. Vomiting did not immediately occur. Not long afterwards milk was drunk, and vomiting took place at once. Three hours after the attempt the patient was admitted into the Charité, where the stomach was immediately washed out. The patient was doing well. It was not possible to determine the part of the stomach from which the necrosed tissue came, but it was conjectured that it was from the neighborhood of the pylorus.—*Med. Press*, April 23, 1890.

Brown (H. H.) on a Case of Acute Chorea Terminating Fatally from Acute Paralytic Distension of the Stomach.—A girl of sixteen had acute rheumatism in August. In October she developed severe chorea with a febrile temperature and pulse and the general

appearance of typhoid fever. Treatment availed nothing and the patient died on the thirteenth day. At the autopsy the stomach was found to occupy the entire abdominal cavity and contain nearly two large basins full of a greenish-brown fluid of about the consistency of thin pea soup. The color was due to acid hæmatin. The mitral valve showed the beading of recent endocarditis.—*Lancet*, April 19, 1890.

McNaught (J.) on a Case of Dilatation of the Stomach Accompanied by the Eructation of Inflammable Gas.—A factory operative twenty-four years of age, a tall and rather spare man, somewhat pale, but not anæmic, gives a history of stomach trouble dating back four and a half years. At the beginning of the time he suffered chiefly from pain after eating, but for the last three years his greatest complaint had been of acidity and flatulency. He has occasionally but only rarely vomited, mostly after dinner, but never at any time has he brought up any blood, nor such copious quantities as would point to ectasia. During the last two years he has suffered most severely from flatulency and in connection with this the most remarkable feature of the case made itself evident. His work requires him to rise early, and on one occasion after striking a match to see the time, and when holding it near his mouth, an eructation of gas from the stomach took place. To his consternation the gas took fire, burned his face and lips considerably, and set fire to his moustache. On a subsequent occasion a similar accident happened. At the time I saw him flatulency was extreme and persistent from one meal to another, and he was also much troubled with rancid and sour eructations. His appetite was good, tongue broad and pale, and bowels regular. In examining the abdomen the subcutaneous fat was noticed to be less than normal; there was a deep depression running across the abdomen a little above the umbilicus, but below this there was evident distension and marked tympanites. The lower line of stomach dulness was about three inches below the naval on the left side, and from this point it extended in a curved line to the right, where it reached the level of the umbilicus. A semilunar area of dulness showed the presence of a considerable quantity of food in the stomach, and above this a highly tympanitic note was given extending up into the left hypochondrium. Occasionally a splashing sound could be well elicited, but on other days it was absent. There was a little, but not marked, tenderness midway between the umbilicus and the ensiform cartilage. It was evident from these signs that the stomach was dilated. The stomach-tube was used on several occasions about five hours after meals, and quantities of fluid and *débris* of food varying from one to two pints or more obtained. At first it consisted of a soupy matter smelling exactly like sour yeast, and when it was allowed to stand, a layer of frothy stuff half an inch thick, like dirty yeast, formed on the top. This was full of bubbles of gas which could be seen forming and bursting as it stood in the vessel, while below there was a considerable quantity of clear fluid through which gas bubbles could be seen rising, and at the bottom there settled a sediment of grumous remains of food in a very fine state of division, resembling the sediment from pea soup. The fluid after filtration gave an acidity equal to 3.2 grammes of caustic soda per litre, and it was found to contain 0.55 gramme per litre of volatile acid, and 0.18 gramme of lactic acid per litre, the residue, equal to 2.4 grammes of caustic soda, being due to mineral acid or acid salts. A strong reaction was obtained with methyl blue and congo red.

The microscope showed enormous quantities of yeast and some sarcinæ, with various remains of food. At first I was unable to detect any bacteria, but subsequent more careful examination of the clear fluid showed their presence in great numbers. The fluid extracted from the stomach a week later gave an acidity equal to 2.44 grammes of caustic soda per litre, and of this 0.26 gramme was due to volatile acid, and 0.4 gramme to lactic acid. One hundred and fifty cubic centimetres were put in a flask connected with a gas-collecting apparatus, and kept at a temperature of 100° F. In a few hours forty cubic centimetres of gas came off, and when a light was applied it exploded with a loud report and burnt with a blue flame. Analysis of a portion of the gas subsequently collected, which I owe to the kindness of my friend Dr. Bailey, of Owens College, Manchester, gave

CO_2 — 56 per cent.
H — 28 " "
CH_4 — 6.8 " "
and residual air 9.2 " "

That the inflammable gas existed in the stomach itself was put beyond question by pouring water into it in a thin stream through a tube and igniting the gas as it issued therefrom owing to the displacement. Only one experiment of this kind was made, as the result of the first was to produce a flame of dimensions alarming to both the patient and myself.

As a result of various fermentation and culture experiments it was determined that the inflammable gas was developed by a rod-shaped bacillus closely resembling the clostrydium butyricum.

The patient gained considerable weight and was very much benefited by daily washing out of the stomach by a weak antiseptic solution and the administration of the salicylate of soda in fifteen to thirty grain doses.—*Brit. Med. Jour.*, March 1, 1890.

Henry (F. P.) on Functional Disorders of the Stomach.—There are, at least, two kinds of pyrosis, one due to an excess of lactic acid and the other to an excess of hydrochloric; and the time-honored treatment of this symptom, without reference to its cause, has been the administration of sodium bicarbonate. The following experiment of Bourget shows that this drug, in the commonest form of pyrosis—that caused by an excess of lactic acid—is, at most, an evanescent palliative. To a patient with chronic gastric catarrh and dilated stomach, was given a certain amount of soup, some of which was withdrawn two hours later, and found to contain 1.68 per cent. of lactic acid and no HCl. It was then exactly neutralized with sodium bicarbonate and placed in an incubator. At the end of half an hour it contained four per cent. of lactic acid. It was again neutralized and about eight grains of sodium bicarbonate added in excess. At the end of an hour free lactic acid was found. On the other hand, HCl given during a meal was found to prevent the formation of lactic acid. This corresponds with the physiological fact that the lactic acid formed during the first half hour of digestion is speedily suppressed by HCl. Bicarbonate of sodium undoubtedly neutralizes any lactic acid that may be present in the stomach, but instead of preventing its further formation, seems to increase it by creating an alkaline medium favorable to the growth of the organism of the lactic-acid fermentation. Lactic-acid pyrosis, therefore, is to be treated by the administration of HCl during, or immediately after, a meal.

Pyrosis hydrochlorica may be due to hyperacidity or hypersecretion. In the first instance, it is to be treated by the administration of an alkali several hours, from four to six, after a meal. In hyperacidity the gastric juice is abnormally active, its physiological work is soon performed, and then it expends its superfluous energies upon the unfortunate patient. Having waited until its work is done, it is rendered powerless for mischief by the administration of an alkali, just as in peptonizing milk we boil the mixture or place it on ice to prevent the process from going too far.

The most successful treatment of hypersecretion consists in the methodical washing out of the stomach, preferably just before the principal meal, and the administration of alkalies. The latter should be given in large doses, for, as is well known, the administration of a small dose of an alkali will be followed by an increased secretion of gastric juice. Thirst is often excessive in these cases, but water should not be allowed except in small quantities, as it tends to increase the dilatation which is usually present.

When the sense of thirst becomes unbearable, it is better to obtund it, as Riegel suggests, by the administration of small doses of opium than to permit the ingestion of large quantities of water. The diet should, at first, consist exclusively of albuminous substances, as carbohydrates are only partially digested, and by their fermentation aggravate the disease.

Dr. Roberts of Manchester, observing a profuse flow of saliva in cases of acid dyspepsia, and believing it to be a provision of nature for relieving the surplus acidity of the stomach, recommends the use of substances that will provoke its secretion, such as gum lozenges containing a small amount of ginger, cayenne pepper, or pyrethrum. He has thus experienced relief in his own person and given it to others.

In cases of motor insufficiency, in addition to general hygienic measures, the vegetable bitters, especially strychnia, and alcoholic stimulants may be used with advantage. Klemperer found that both substances hastened the exit of food from the stomach.

The treatment of nervous dyspepsia

must vary with the cause producing it. One case will be cured by restoring the uterus to its normal position; another by curing a chronic constipation, or expelling a tapeworm; still another by allaying an irritation of the spine.

A restricted diet, or one of milk only, which is always beneficial in catarrh, is of little or no benefit in cases of nervous dyspepsia. General supporting measures, massage, electricity, the bromide salts, and if anæmia exists, arsenic and a mild non-constipating preparation of iron, such as the potassio-tartrate, are the chief indications. I believe also, from a limited experience of the measure, that lavage may sometimes be of decided service in soothing a hyperæsthetic mucosa.—*Med. Progress*, March, 1890.

Ball (C. B.) and Scott (J. A.) on Rectal Neoplasms.—Dr. Ball said that the views he had advanced as to the causation of these fibrous polypi from ordinary internal piles were clinical rather than pathological. They found ordinary internal piles in the first instance soft and brightly vascular, consisting of a lot of very loose connective tissue covered with mucous membrane, and containing a large number of very dilated veins, thrombosed with laminated clots, and, very frequently, arteries of moderate size. But if they examined sections of piles which existed for many years, they would find that the connective-tissue element had greatly increased, while the vascular element was not at all a noticeable feature, and as they went still further on, the formations became pedunculated. The view that these originated in piles was more based on clinical observation than microscopic examination. With regard to Prof. Symington's theory that the anus was a canal and not an opening, it explained many things that he (Dr. Ball) had been unable satisfactorily to account for before—one being the height to which, under ordinary circumstances, the mucous membrane was to be met with; and another, that tumors which were perfectly reducible were found within the rectum, and not appearing externally, and still covered with squamous epithelium. The canal was lined with skin till it joined with the mucous membrane; but in frozen sections the canal appeared to have very little existence. Of course the conditions were very different during life and after a frozen section had been made, for after death the sphincter was relaxed, and then, to a certain extent, there was an open cavity; whereas, during life, it was closed. A digital examination would convince any one of the truth of Professor Symington's observation.—*Med. Press*, March 19, 1890.

Hodenpyl (E.) on Enormous Dilatation of the Heart.—The heart was removed from the body of a man about twenty-one years of age. He was found on the street suffering from the most intense dyspnœa, and was carried as quickly as possible to the hospital. There it was found that the area of cardiac dulness was greatly increased, and it was supposed that the case was one of pericarditis with effusion. The man's condition was such that it was impossible to get a satisfactory history of the events preceding his admission to the hospital. There was extreme cyanosis, and the dyspnœa was most painful. It was determined to tap the pericardium, but before this could be done the man died. At the autopsy the heart was seen to be greatly dilated, measuring seventeen inches in its greatest circumference, and nine inches in its longest diameter. When cleared of all clots, it weighed about forty ounces. One cusp of the aortic valve was nearly destroyed, but the mitral appeared to be normal. The pericardium was adherent. Dr. Hodenpyl said that the question had arisen in his mind whether it would not have been justifiable to aspirate the heart, even if the true condition had been known. The patient was suffering greatly from dyspnœa, and the operation might have given him a little relief before he died.—*Med. Record*, April 5, 1890.

West (S.) on Paroxysmal Hurry of the Heart.—Under this designation he includes cases in which there is well-marked but ephemeral rapidity of the heart's action associated or not with pain, and with which a cardiac lesion may be, but is not necessarily, or at any rate obviously, connected. He pointed out that, except during the attacks, the affection did not, as a rule, incapacitate the sufferer from following his or her avocation, and some of them recovered, though others died with symptoms of cardiac failure, a fact which points to the existence of some cardiac lesion as a complication, if not as a cause. He mentioned three such cases, two in men, aged thirty-three and thirty-two respectively, and one in a nurse of twenty-six. He insisted upon the importance of suggestion as to the

nature of these phenomena, and joined issues with Dr. Bristowe, who regards the symptoms as due to functional disorder, any cardiac lesion being secondary to the attacks of palpitation.—*Med. Press*, March 12, 1890.

Benham (F. L.) on the Treatment of Hydrophobia.—Of the various modes of treatment, it seems to me that, of any single kind, very copious bleeding is the surest. Mercury alone or combined with it is also tolerably sure. Only a few cases have been reported of failure after *very large* bleedings. Cold affusion or vapor baths may also be successful, or sweating may be induced by pilocarpine. Curare also, if pushed decisively, promises fairly well. Chloral and chloroform may be useful to lessen the violence of the paroxysms, and may sometimes subdue them altogether; but morphia, especially in small doses, is not to be relied upon, even to procure relief, for it often only aggravates the disease.—*Lancet*, March 15, 1890.

Acute Contagious Pemphigus.—Dr. Knud Faber reports a small epidemic of this trouble (*Monatshefte fuer praktische Dermatologie*) in a children's hospital, which he had an opportunity of observing and of studying. This analysis has led him to the conclusion that there exists a variety of pemphigus observed in children which is of a contagious nature. That it is local is proven by the fact that external measures, such as soap baths, produce a rapid cure. The contagious nature was demonstrated by the good results which followed isolation. A search for the germ resulted negatively. The staphylococcus pyogenes aureus, and albus were found in the contents of the bullæ, but are regarded as being accidental, as experimental inoculation failed to reproduce the disease, and, in some cases, caused abscesses. Some have contended that the bullous form of impetigo contagiosa is closely allied to this trouble, and that this in turn is a bullous form of trichophytosis.—*St. Louis Med. and Surg. Jour.*, May, 1890.

Salvage (J. V.) on a Case of Acute Pemphigus, with Transference of the Local Lesion by Direct Contagion.—A female child, on the third day after birth, developed a pemphigus eruption, which soon invaded the entire surface, except the palms and soles. Four days before the bullæ ceased to be formed on the child, several appeared on the breasts and forearms of the mother. One, a little below the left nipple, was as large as a sixpence, three others on the chest were smaller; on each forearm there were about twenty, the size of peas. They were most numerous on the front surface; none occurred on the palms or on any other part of the body. In appearance they exactly resembled those on the infant; they lasted three or four days, and no fresh ones developed after they ceased to be produced on the child. They were evidently the result of direct local contagion. The mother, who always wore short sleeves, alone nursed the child; indeed, during the three or four days and nights which preceded the eruption on her chest and arms, she spent nearly the whole of the time sitting on a chair with the child in her lap. Slight itching followed the bursting of the bullæ, but there were no constitutional symptoms, and no treatment was needed. Both child and mother have remained quite well during the three months which have elapsed since the attack. There was no suspicion of syphilis in the case.—*Lancet*, April 19, 1890.

Draper (T. J.) on Rigor Mortis in Utero.—I was called, on February 24th, to see Mrs. R., primipara, who was in her seventh month of pregnancy. A few days before she had sustained a fall or jar; she struck on her feet, but was considerably shocked. She had severe pain in her back, but no labor pains. I prescribed rest in bed, and gave morph. sulph. gr. ¼, fl. ex. hyoscyamus gtt. x., fl. ex. ergot. gtt. x., fl. ex. blackhaw gtt. xx., to repeat every two hours if needed. She went on from bad to worse, and when I was again called, on the night of the 26th, I found her in hard labor. She was considerably narcotized and semi-delirious, as they gave more medicine than directed, in the hope of stopping the pain. The labor was "dry" and tedious, but there was nothing unusual about it. I ruptured the membranes just before delivery; there had been no waste of waters previous to this time, and a very little then.

When born, the child was rigid. There is no doubt about it; I gave it a close examination. The legs and arms could be moved only with force. It must have been dead some days, but there was no decomposition.

Admitting that she had been given too much medicine and that the hyoscyamus caused her delirium, could it have caused

the death or rigor mortis of the fœtus? She was on this prescription nearly three days, but was overdosed not over three hours before the delivery. She made a good recovery.

"What prevents rigor mortis of fœtus in utero?" is a conundrum for medical students. But I would like to know what caused it in this case, as I have a fear that the hyoscyamus was the cause of the child's death. It is true this child was hardly viable, but the question is just as pertinent. — *Weekly Med. Review*, April 19, 1890.

Tuberculosis by Inoculation. — A fair number of cases are now on record in which tuberculosis has been caused by accidental inoculation. Thus, many "post-mortem warts" have been proved to contain tubercle bacilli, and a case occurred some time ago in Vienna of a porter who pricked his finger whilst sewing up the body of a patient who had died from phthisis, and upon whom an autopsy had been performed; tubercular nodules appeared on the porter's arm, which on microscopical examination exhibited tubercle bacilli, and he eventually died of miliary tuberculosis. Another case of accidental inoculation is reported by Dr. Deneke, of Hamburg, in the *Deutsche medicinische Wochenschrift*, of March 27th of this year. A child, aged seven months, accidentally fell, its head striking and breaking a chamber utensil, into which the mother was accustomed to expectorate. The mother, aged twenty-five, was found to be suffering from phthisis of the left apex, and tubercle bacilli were found in her sputum. The child on being taken up was found to have received three superficial cuts on the head; these were carefully cleansed with corrosive sublimate solution, and dressed at first with iodoform, and later with corrosive sublimate compresses. The wounds healed in a week. Six weeks later the child was again brought to Dr. Deneke, who found that two of the scars were swollen and congested, and there was also a painful swelling in the region of the left parotid. The two wounds on the head gradually broke down, and small ulcers formed. An abscess formed behind the left ear, starting from an enlarged gland; in the discharge from this abscess tubercle bacilli were found. The child improved temporarily, but soon became worse again, and died four months later. At the post-mortem examination caseous glands were found in the neck, in addition to the abscess above mentioned. The bronchial glands were healthy, and only one of the mesenteric glands showed caseous change. Two tuberculous nodules were found in the spleen, but otherwise no signs of tubercle were found anywhere in the body; the lungs were healthy. This is an interesting case of tubercular inoculation. It is quite analogous to those cases in which infection has been received from broken spittoons, although it differs from these in that tuberculosis did not become general.— *Lancet*, April 26, 1890.

Quinsy in a Very Young Child.— Dr. Horace Clark reports, in the *N. Y. Med. Jour.*, April 26, 1890, a case of undoubted acute tonsillar abscess in a boy fourteen months old. Recovery supervened.

Precocious Gonorrhœa.—Dr. F. M. Crandall reports, in the *N. Y. Med. Jour.*, April 26, 1890, an instance where a boy of six acquired gonorrhœa by sleeping with an infected uncle, and considerately shared his acquisition with his sister aged eight, to whom he transmitted the culture in the old orthodox but *un*fraternal fashion.

Contagious Pneumonia.—Dr. Mosler, in a paper read before the Greifswald Medical Society, gives details of a series of cases of acute pneumonia in a family where there seemed every reason for believing that contagion was the cause of the spread of the disease. The patients were all attacked during the last fortnight of January, 1889, the first to fall ill being the father, who died on the 22d, the fifth day of his illness. On this day his wife was attacked, and she too succumbed on the fifth day of the disease. Whilst she was ill, her son, who constantly visited his parents during their illness, himself was attacked on the 26th. He was thirty years of age, strong and temperate, but succumbed on the twelfth day of the attack. Further, his sister, who had come from Arendsee, near Stralsund, to be with her sick parents, and who stayed in their house from the 22d to the 26th, was attacked at Arendsee on the 29th, and was admitted into the Griefswald Hospital. She alone recovered. Dr. Mosler points out that the parents' house was dry, the two rooms they inhabited were well ventilated and clean, and that there had been no illnesses in the house within the past five years. He thinks the father must have acquired his pneumonia outside, and

that the disease was communicated in turn to the members of his family by contagion through the sputa. In the case of the son a post-mortem examination showed that the form of pneumonia was not the typical one : it was more lobular, was accompanied by a hemorrhagic pleurisy, and by swelling of the spleen. Moreover, an examination by Professor Grawitz of some of the fluid withdrawn from the lung of the daughter during the height of the disease resulted in the discovery of bacilli resembling those of rabbit septicæmia, but neither the pneumono-bacillus of Friedländer nor the pneumonococcus of Fraenkel was found. In the case of the son the blood from the heart yielded a similar micro-organism. Dr. Mosler thinks that such facts, as well as the peculiarities of the morbid anatomy of the latter case, suggest the occurrence of a special form of pulmonary inflammation, owning a cause different from that of the ordinary form. He sees in such cases a reason for believing that many varieties of poison may give rise to pneumonia. But the main lesson from the cases is that of contagiousness, and the need for the careful disposal and disinfection of the sputa, which he believes to have been the infective medium in these cases. He refers to recent contributions of Finkler and Cantani on infectivity of pneumonia, the latter recording some striking instances where the disease was more of the lobular than the lobar type.—*Lancet*, Jan. 25, 1890.

The influence of Cold in Pneumonic Infection.—Dr. G. Lipari, of Palermo, in his recent experiments on the infectious nature of fibrinous pneumonia, essentially confirms what is known of Fraenkel's pneumonococcus, and has also succeeded in proving the influence of cold as a factor in the origin of fibrinous pneumonia. The endotracheal injection of pneumonic sputa or pleuritic exudation of animals which had died from pneumonococci gave a negative result, but when the author, before or after the endotracheal injection, exposed the animals to cold, the result was very different. Of eight animals so treated six died with clearly established pneumonic infiltration. The author supposes that the cold paralyses the ciliated epithelium of the bronchi, and at the same time causes their mucous membrane to swell, both of which pathological processes favor the descent of the infectious material into the alveoli. These experiments were doubtless undertaken with a view to harmonize the old and new teaching upon the origin of this prevalent disease.—*Lancet*, Feb. 22, 1890.

Alrich (W. M.) on a Case of Typhoid Fever Complicated by Typhlitis.—J. N., æt. nineteen, a laborer, with a negative family history, was taken ill September 22, 1889, with loss of appetite, slight diarrhœa, and aching limbs. Had no pain, no nose-bleed, no abdominal tenderness, gurgling, or distension. Five days later persistent vomiting set in.

All these symptoms increased in severity until he was admitted into the hospital two weeks from the onset of the disease. At this time his condition was as follows : Loathing for food, persistent vomiting, unable to retain even a drink of water ; several typical typhoid stools per day, a greatly distended abdomen with marked tympany all over it, and in right iliac fossa a distinct tumor, boggy to the touch, flat on percussion and very painful on pressure ; temperature 98.3, pulse 100, respiration 28. Had moderate hypostatic congestion at base of left lung. Every examination of urine negative. Tongue moist and only moderately coated. Diarrhœa continued throughout the course of the disease. At no time was his temperature very high, ranging from 98° to 101°. No rose spots of typhoid were ever present.

His treatment was as follows : Creasote in two-drop doses three times a day until vomiting ceased ; stimulants, milk diet, subnitrate of bismuth in fifteen-grain doses every four hours, a pill consisting of one quarter of a grain of silver nitrate and one eighth of a grain of extract of belladonna every four fours. Since he seemed to be quite susceptible to belladonna, which soon showed its activity by dilatation of the pupil, the pill was discontinued and extract of opium was substituted to check diarrhœa and control nervous symptoms.

The abdominal symptoms were most persistent, and in spite of turpentine applied locally in the form of stupes, and taken internally in emulsion, and various other remedies, the distension was marked for over two weeks, as was also the indurated mass in the right iliac fossa. At this time he was given calomel in one-tenth-grain doses every two hours, which evidently did good ; the distension became less marked, the mass in the right iliac

fossa slowly decreased in size, and eventually disappeared.

The patient's general condition continued to improve, and he was discharged on November 22, 1889.—*University Med. Mag.*, Feb., 1890.

THERAPEUTICS.

Reichert (E. T.) on the Action of Caffeine on Tissue Metamorphosis and Heat Phenomena.—As a result of fifteen elaborate experiments on dogs, the author concludes that caffeine increases heat production and, as a corollary, increases destructive tissue metamorphosis. This being the case, how are we to explain the efficiency of coffee in supporting the system and enabling the performance of as much, or even more, work under conditions of restricted diet? It may be supposed, as already suggested, that the actual waste of energy is in some way diminished, as, for instance, by a lessened heat dissipation, the quantity of heat thus concerned becoming apparent in work; but this assumption is nullified in the facts just demonstrated, that both heat production and heat dissipation are increased, and accordingly that the actual waste of energy was greater. There seems to be no other explanation than that the virtues of coffee in the wear and tear of active life are entirely subjective and depend upon a general excitation of the higher tissues, and chiefly upon its powerful exhilarant action on the mental processes. The assumed ability of coffee to replace food, or to increase the power for work without corresponding tissue destruction, is consequently entirely deceptive and the conditions produced by it are comparable to those observed at times in the insane, in hysteria, or in fright, where the individual may be capable of performing prodigious feats of strength and endurance, but, nevertheless, at the direct expense of his tissues.—*N. Y. Med. Jour.*, April 26, 1890.

McCall (R. B.) on the Salicylate of Cinchonidine.—The author considers this new combination almost a specific for cases in which symptoms of both rheumatism and neuralgia are manifested.

To explain how salicylate of cinchonidine is more effective in these states than salicylic acid or the salicylate of sodium with sulphate of quinine would be difficult, and if accomplished would possibly have little practical value. Salicylate of cinchonidine probably owes none of its efficacy to its relationship to quinine, but solely to qualities engendered by the union of cinchonidine with salicylic acid. Given alone, its antiperiodic effect is very inferior to that of quinine, but exactly adequate to the demand in the present instance. The well-known value of salicylic acid in both rheumatism and neuralgia is increased by its intimate association with cinchonidine, and thus the two together, considered on theoretical grounds alone, must be acknowledged to possess those therapeutic qualities that are needed to meet the above-described indications.

The writer states that with more or less strongly pronounced signs of rheumatism and neuralgia, such as pain or soreness and stiffness of the loins, with or without impairment of function of the smaller joints, with a history of previous similar attacks, and no permanent organic lesion, most satisfactory and, in a great majority of cases, lasting relief will follow the faithful administration of salicylate of cinchonidine.—*Med. News*, April 26, 1890.

Stiller on Salicylate of Sodium in Cholelithiasis and Pleurisy. — The author has used salicylate of sodium as a cholagogue for five years and has found it better than any other drug in rapidity and certainty of effect. He gives the following illustrative case, which is one out of many: A man, aged fifty, had suffered for about four months almost daily from severe bilious colic, and had been jaundiced for about three months. Rigors, with a temperature of 40° C., frequently occurred. He was so emaciated that his appearance suggested cancerous cachexia. The liver was enlarged and resistant, but smooth. The gall-bladder could not be felt. After a week's treatment with salicylate of sodium the pains and fever disappeared, the icteric color decreased, vomiting ceased, and after a four weeks' stay in the hospital he was dismissed cured. The details of the mode of treatment are as follows: Half a gramme of the salicylate was given four times a day. It was given in half a glass of soda water, or any other alkaline water—never in wafers, as these increased the gastric irritation. Usually 0.01 gramme of the extract of belladonna was added to each dose, as a non-constipating anodyne. Linseed poultices were applied over the

liver. The patient was kept on moderate diet for several days, and alkaline water, free from iron, was given as beverage. Occasional pains were relieved by injections of morphine. Carlsbad and Vichy water was ordered by way of after-treatment. The cholagogue properties of the drug had also been proved by experiments on animals. In cases of pleurisy, Professor Stiller had noted a very striking diminution of the effusion when salicylate of sodium was given. Absorption occurred in a surprisingly rapid way, and Dr. Stiller recommended the drug, even for diagnostic purposes, as excluding the purulent character of the exudation. From three to four grammes in solution were administered daily, a spoonful being given every hour or two hours. The primary effect, no doubt, was on the kidney and the increased secretion of urine favored absorption. It was only recently that he had observed, in a case under his care, that the quantity of urine was increased from 650 to 2,000 and even 2,300 cubic centimetres under the influence of salicylate of sodium. The drug was also useful in sciatica.—*Brit. Med. Jour.*, April 5, 1890.

Lane (J. E.) on the Treatment of Gonorrhœa by Salol.—I have for some time past been prescribing salol in the out-patient department of the London Lock Hospital, and am now enabled to give the results of its administration in fifty cases of gonorrhœa. I have tested the value of the drug in urethral discharges at all stages, in some cases relying solely upon its use, in others employing an astringent injection in addition. An analysis of the fifty cases shows that six were cured, twenty-four showed considerable improvement, in fifteen cases no change either for better or worse was noticed, while in five cases the symptoms were aggravated. The doses used were from five up to thirty grains, taken three times daily. The beneficial effects of salol manifest themselves in a very short time. When improvement takes place the symptoms show an abatement in from two to seven days; in acute cases the painful micturition is early alleviated; in cases of a more chronic nature the discharge is materially lessened in this time. In ten cases an injection was employed in conjunction with salol; this was when I commenced my trial of the drug, which I gave at first in five-grain doses. I subsequently increased the dose to ten, twenty and in a few cases to thirty grains, and relied upon its internal administration without the assistance of injections; out of forty cases so treated an improvement was noticed in twenty within a week, while six were completely cured. Salol is not a mechanical mixture of carbolic and salicylic acids, but appears to be a compound of the nature of an ethereal salt, since phenol can, with some slight difficulty, be obtained from it on saponification. The potassium salt left after the treatment of salol with caustic potash gives with hydrochloric acid an acid which is either salicylic or one of its isomers. Four hours after administration by the mouth of twenty grains of salol traces of carbolic and distinct evidence of salicylic acids, combined with other elements, were found in the urine. In one case the urine was blackened as in carboluria, the patient at that time taking thirty grains three times a day. It is by the action of the pancreatic juice that salol is said to be split up into carbolic and salicylic acids; of this change I was unable to procure any sufficient evidence after having added pancreatine to a mixture of salol. In salol we have, in my opinion, an addition of considerable value to our list of remedies for gonorrhœa; its effect is apparently produced by the action of the urine upon the inflamed urethra, since that fluid contains salicylic and carbolic acids in combination, probably as salicylurates and sulphocarbolates. It may be given in doses of from ten to twenty grains three times daily at any stage of the disease, and in chronic cases an astringent injection will materially hasten the cure. The effect of the drug does not appear to be enhanced by larger doses than twenty grains; when the amount was increased to thirty grains, the urine became blackened and the symptoms did not show any proportionate improvemen. I commenced by giving five-grain doses, but this was soon discovered to be too small a quantity, and my results would, I doubt not, have been more favorable had I commenced its administration with a freer hand.—*Lancet*, March 22, 1890.

Warfield (R. B.) on Carbolic-Acid Gangrene.—Carbolic acid applied to a skin surface may bring about rapid death of the part; and the gangrene thus produced is always sharply circumscribed and corresponds to the skin area in relation with the drug. This gangrene is apt to be

produced only when the entire circumference of the part is in contact with the destructive agent; and the strength of the solution employed seems to be of less importance than the length of time of its application. The employment of a strong solution of carbolic acid to the whole circumference of an extremity should be condemned, as should also that of even a very dilute solution when continued for a considerable time.—*Med. News*, April 12, 1890.

Young (E. W.) on Poisoning with Antipyrine.—A man of 45, three weeks convalescent from neuralgia of the bowels, came into my office, complaining of a slight attack of sick headache. I administered, at 9 A.M., about six grains of antipyrine, dissolved in water, with one fluid drachm of whiskey. In three minutes after taking the mixture the patient spoke of a peculiar sensation upon each side of the fauces. In ten minutes he left my office to go to his business. Unpleasant symptoms, such as a tumor-like sensation over the notch of the sternum, accompanied with slight dyspnœa, occurring soon after leaving me, he returned after being absent from the office fifteen or twenty minutes, considerably alarmed and with appearance of much suffering. He complained of severe pains in the shoulders, extending up along the side of the neck and down the arms, in the groins, extending down the inner surface of the thighs, and in the mediastinal region. He was also troubled with vertigo, dimness of vision, and nausea, though he did not vomit. Concluding that the whole quantity taken had been at once absorbed into the circulation, I immediately began the use of cardiac stimulants and anodynes, through the stomach. The pulse was increased in frequency and somewhat weak, though regular in rhythm, the highest rate being reached after one hour, 108 per minute, and continuing such for two or three hours.

Within fifteen minutes after returning to me the pain became less severe, when he then began to itch intensely, first over the region of the back but soon spreading to all parts of the body, and after a very short time an eruption, identical with that of urticaria, covered nearly the whole surface, continuing more or less severe for three hours, then subsiding entirely. The pain last to be dispelled was that in the neighborhood of the stomach and mediastinal region. Toward 4 P.M. the patient expressed himself as feeling "all right" again and so continued.—*Med. Record*, April 12, 1890.

Worthington (L.) on Cyanosis from Monobromacetanilide.—In the first case, a girl, aged 19, woke early in the morning with a severe headache, and at 11 A.M., took 5 grains of monobromacetanilide. The headache was not relieved; so eight hours later she took five grains more, though her friends noticed she was rather pale and dusky at the time. At 10 P.M., lips, cheeks, and fingers were deeply cyanosed; pulse 120, small and soft; she was restless, complained of headache, and said she felt she was dying. At midnight, pulse 140, small; complains of a rushing noise in her ears, and throws herself about restlessly, like one who has lost much blood. At 6 A.M. she attempted to get out of bed, and fainted; after this the headache lessened and the cyanosis gradually diminished, though it was still appreciable at 6 P.M. During the night menstruation came on, she slept well, and was quite recovered in the morning.

The second case was that of a woman, aged 33, who had previously on several occasions taken 5-grain doses of antifebrin for headache, with uniform benefit. A severe headache came on at night, when she took 4 grains of monobromacetanilide, and an hour later repeated the dose, in spite of a caution to the contrary. The headache was somewhat relieved, but in the morning she was blue and faint, and she staggered on attempting to walk. The pulse was 80, regular and soft, but not small. She was treated with ether and ammonia, and by the evening the headache and cyanosis had passed off, and menstruation had commenced.

In the first case menstruation was not due for ten days, but there had been previous irregularity; in the second not for three days.

I have seen the drug tried with men in similar doses without any such symptoms; though the good results were in no case as marked as with antifebrin.

Great caution is required in accepting evidence that the usual reaction of drug and organism may be interfered with by menstruation, and the occurrence of these three cases may be nothing more than a curious coincidence; at any rate, the monobromacetanilide would appear, under some circumstances, to be an unstable body,

and liable to molecular change to a toxic substance, possibly aniline; so that it may be followed by unpleasant symptoms even when given in small doses.—*Brit. Med. Jour.*, Feb. 15, 1890.

Thompson (J. T.) on Superficial Keratitis Induced by Aniline Violet.—A healthy boy, aged about 7 years, had been amusing himself by dawing with an aniline blue pencil, and had got his fingers well stained with the violet dye, and from these had got it into the left eye. When the mother first noticed the child, "the white of the eye (as she put it) was quite purple." But the child made no complaint. Towards evening the eye got very irritable with photophobia and lachrymation. In the morning the purple color had faded considerably, but the child had great dread of light and pain. On examining the patient, after installation of cocaine, I found the conjunctiva extremely congested and of a reddish-purple color. After reducing the superficial hyperæmia by pressure, the color was of a bluish-purple. At the inner side below was an area of deeper circumcorneal injection. The pupil was slightly dilated and active. On examining the cornea by oblique illumination, I found six small vesicles on the inner and lower segment, filled apparently with transparent fluid; one of these had burst and left a small superficial ulcer with clean edges. There seemed to be no infiltration of the corneal tissue around, the media was clear, and the fundus normal. I ordered atropine, cocaine drops every three hours, and boracic acid lotion, the eye to be protected from light. Next day all the vesicles had burst and coalesced to form one superficial ulcer, the floor of which was quite transparent and the margin showing no infiltration. There was much less photophobia, and the violet staining of the conjunctiva was much less marked. The atropine was continued and a light compress applied, and in forty-eight hours the ulcer had completely healed. There was a slight haze over that part of the cornea for a day or two, but eventually it became perfectly transparent, and full vision returned. The purple stain had entirely disappeared on the fifth day.—*Brit. Med. Jour.*, April 12, 1890.

Cain (J. S.) on the Use and Abuse of Antipyretics.—The author is convinced that pyrexia is not only most often an unimportant factor in disease, which does not require any special treatment, but that sometimes and in certain characters of fever, it is one of nature's efforts at repair which should be encouraged, and to combat or antagonize it, in the sense of arresting its generation, is to try to defeat the very conservative and reparative processes by which nature is struggling to preserve the life of the patient.—*Med. Record*, May 3, 1890.

Farlow (J. W.) on Resorcine in Whooping-Cough.—After trying cocaine in two cases of whooping-cough, the author began the use of the two per cent. solution of resorcine with a compressed air apparatus. It was sprayed into the nose, the pharynx, and larynx every two hours. The first day he noticed but little change, but the younger child slept from eleven at night till four in the morning without coughing. The next day the paroxysms were much less frequent, and the children slept practically all night, and by the fourth day the cough had disappeared and the children were perfectly well. The atomizations were continued for a few days as a precaution, but there was no return of the cough, and the children remained in perfect health. For the younger child he also used at night what is called cresoline, apparently an impure creasote. He heated this over a lamp and the dense fumes, smelling like carbolic acid, filled the room.

The symptoms of both cases were so marked that the diagnosis was certain. Other cases from the same school, less severe, lasted over two months, whereas these two cases were apparently aborted by the treatment. He had charge of two other young children soon after, one six and the other two. He showed the mother how to use the atomizer, and these cases were very soon relieved. The mother told him that the cough was practically gone in a week after treatment was begun, while three children in the next house continued to cough for two months. In all cases the relief was immediate and very marked, the disease seeming to be choked off.—*Boston Med. and Surg. Jour.*, Feb. 27, 1890.

Partridge (C. C.). Epithelioma Cured by Repeated Applications of Permanganate Potash and Resorcin.—The disease consisted in an epithelioma near the inner canthus of the left eys, which had resulted from the constant irritation of a small wart appearing there twenty years before. The growth was an irregularly shaped ulcer, ¾ inch by 1¼ inch in size.

A strong solution of permanganate of potash was first applied, and then an ointment consisting of resorcin 15 parts, vaseline 20 parts, which was allowed to remain on about fifteen hours. These applications were repeated daily for a week. A simple ulcer was left, which healed in a few days, leaving only a suspicious-looking nodule the size of a split pea, which was removed by Marsden's paste.—*Kansas City Med. Index*, April, 1890.

Glycerinum Saponatum.—Dr. Hebra describes this preparation as an alkaline fat obtained in the manufacture of soap, which is dried, then cut into small pieces, and dissolved in glycerine. This product is again heated and filtered and allowed to cool, when it forms a soft, yellow, transparent, and somewhat elastic mass, which is perfectly odorless, melting at body heat, and easy soluble in water. As a basis for ointments he related a number of cases successfully treated by the preparation, and expressed a hope that his colleagues would give it favorable consideration.

He is so confident of the efficacy of this vehicle that he asserts its potency with salicylic acid and creasote to cure that intractable disorder, lupus. His prescription is 90 per cent. of glycerinum saponatum, 5 per cent. of salicylic acid, add 5 per cent. of creasote. This will cure lupus without the slightest pain being experienced. He also assures us that there is no other remedy so powerful as an anti-bacteroide. This preparation is no less powerful in its curative action in tubercular skin diseases, as tyloma, lepra, etc. For the rest of the skin diseases he has different preparations, where glycerinum saponatum is the basis, and all are confidently recommended as efficacious in cutaneous disorders. He admits that he has not exhausted the different combinations with which this vehicle may be administered with as efficacious results.—*Med. Press*, April 23, 1890.

Jassinski on the Treatment of Tuberculosis of the Skin, Bones, and Joints with Balsam of Peru.—He has employed this treatment most frequently after arthrectomy of the elbow-joint. He used the pure balsam, which he obtained directly from the Republic of San Salvador, and on which he could not succeed in cultivating micro-organisms. He agreed with Binz in ascribing the effect of the balsam to the cinnamon which it contained. He had employed it in eleven in-patients and sixteen out-patients. Tuberculosis of the elbow-joint he could cure in from three to four weeks. No other method gave such satisfactory results. No unfavorable after-effects were observed, and a cure was obtained in all the cases. He had used the balsam in tuberculous spondylitis. In these cases he diluted it with alcohol and injected it after three or four days.—*Brit. Med. Jour.*, April 12, 1890.

Baldy (J. M.), on Electricity in Chronic Pelvic Inflammatory Neuroses.—Electricity, I would hold, if I had determined on mere palliation, as a last remedy, for the following reasons:

1. The treatment must be a local one, and must be given by the physician himself.
2. The apparatus is too expensive for any but a specialist to possess.
3. The patient must submit to a prolonged vaginal manipulation several times a week, sometimes for months.
4. It is necessary to remove a great part of the woman's clothing in order to administer the treatment properly and thoroughly.

The absolute failure to cure the disease, which I have shown in one case, I could easily demonstrate in many others.—*Med. News*, March 22, 1890.

Thompson (W. G.), on the Fallacy of the so-called Hot Air Treatment of Phthisis.—The author used a coiled iron cylinder connected with a bellows, the cylinder being heated by a Bunsen burner. Thermometers were placed in the straight horizontal part of the cylinder at varying distances from the nose of the animal inhaling the hot air, and also in the trachea and thoracic cavity. The following case was an example of a number: In a bitch the temperature in the lung previous to the inhalation of hot air was 102.3° F. She was made to inhale for more than an hour air above 200° F., but the temperature in the lung and of the body remained unchanged. The inhaled air was raised to 290° F., when the animal became very uncomfortable and restless, there was evidence of local irritation from the heat, profuse salivation, reddened and swollen tongue. Under these conditions the body temperature rose 1.8°, but as great a rise had been observed in dogs subjected to almost any kind of operation. In the case of a cat the temperature of the inhaled air at the mouth was 250° to 270°

F., continued an hour, the animal showed very decided discomfort, but the temperature rose only two degrees. In another case the lungs of the dog were removed, hot air at 300° F., forced in for nearly an hour, a thermometer placed directly into the lung tissue, yet it was impossible to raise the temperature more than three or four degrees. These experiments showed that when air at a temperature of 300° F. was forcibly driven into the lungs, the moisture was still sufficient to cool it to nearly the same temperature of the body.

In view of the statement which had been made that a temperature of 102° F. retarded the growth of the tubercle bacillus, it was interesting to note that the normal temperature of rabbits was 102.5° F.; of the guinea-pig, 103° F.; of the pigeon and fowls, 108° F., yet it was well known that all these animals were readily affected by tuberculosis.

It had also been stated that the inhalation of cold air was noxious to the tubercle bacillus, and that pulmonary hemorrhage could likewise be checked in that manner. By experimentation he had been able to refute this view also. A dog was made to inhale air below 40° F. an hour and a quarter, yet the temperature in the lung fell only two degrees. A fall of this amount would never prove sufficient to control hemorrhage from the lung by vaso-motor contraction.

The conclusion from his experiments were: 1. That the continued inhalation of air heated from 200° to over 300° F. at the nose did not raise the temperature of the lung at all in some cases, even when inhaled an hour or more; in other instances there might be a slight rise, from two to four degrees, due to other causes. The temperature of the trachea under corresponding condition rose only four to six degrees. Cold air did not affect the temperature of the trachea or lungs any more than did hot air.—*Med. Record*, April 26, 1890.

Stewart on the Use of Borax in Epilepsy.—Case 1, admitted at the age of thirteen, had had epileptic seizures dating from birth, occurring in numbers varying from two to twelve per day, and chiefly at night. She had been under treatment repeatedly, but had derived no benefit. Without treatment the fits during the first week were twenty-six in number, under borax they were reduced to twenty-four in the second and five in the third week. After an interval free from fits of sixteen days, four occurred on two successive nights; then after another interval of nine days a single fit took place, and since that there had been no recurrence of fits—*i. e.*, a clear interval of over a month. Case 2 began to suffer from nocturnal epilepsy at eighteen, and came under treatment five years afterwards. This instance was complicated by serious cardiac disease, stenosis of the mitral orifice. Without treatment the average monthly number of fits was one hundred and one, and under borax this was reduced to twenty in the first month, seven in the second, one in the third, five in the fourth, none in the fifth, and one in the sixth. Case 3 had whooping at seven, followed by left hemiplegia, imbecility, and epilepsy. The average number of fits per week when no special treatment was employed was 3.5, and bromide failed to effect any reduction, for after being under treatment for two years and a half the weekly average had risen to sixteen. Under borax the weekly average during the first month was reduced to 15.5, and during the second month to 11.5. The diminution took place chiefly in the nocturnal seizures. In cases 4, 5, and 7, in which the fits occurred both by day and night, bromide was shown to exercise a decided influence upon the diurnal seizures, leaving the nocturnal practically unaltered, and in these benefit was experienced from the combined use of bromide and borax, three doses of the former during the day and one single dose of the latter at bedtime. Case 6, epileptic and imbecile from birth, came under treatment at thirty-five. The fits were of the nocturnal type; were uninfluenced by bromide, and were slightly diminished by borax. Dr. Stewart concluded that borax exercises a peculiar influence over nocturnal seizures, and that it is in cases where fits are entirely of that kind that the greatest good may be expected; that bromide, on the other hand, exerts a more powerful influence over diurnal seizures, and that in cases characterized both by day and night fits, a combination of these two remedies will be productive of most benefit.—*Lancet*, April 26, 1890.

Quinquaud on the Treatment of Syphilis by Calomel Plaster.—Mercury given under the usual forms for the treatment of syphilis is attended fre-

quently with certain inconvenience, and for that reason he made a trial of several methods, one of which he found as efficacious as it was simple ; he referred to the calomel plaster applied to the splenic region, of which the formula was as follows :

Ordinary adhesive plaster . .	℥ vj.
Calomel	℥ iss.
Castor oil	ʒ iv.

Before applying the plaster the skin over the region should be well washed with soap, in order that the cutaneous functions should be as perfect as possible. A piece of the plaster, about three inches square, is then applied and left eight days, after which period it is removed, and replaced after another eight days. However, in persons who work out-of-doors the plaster might be removed every five or six days. In order to be assured that the mercury thus placed upon the skin entered the system, he examined the urine, and the result was what he expected. Towards the fourth or fifth day traces of the salt were discovered, and about the tenth day considerable quantities were found. Six weeks after the cessation of the treatment signs were still present. M. Quinquaud added that with this treatment he obtained as good results as when the mercury was administered by the mouth or by subcutaneous injection. The method was simple, harmless, and useful. Many persons who dread mercury will not perceive what is being done for them, and the laboring man who otherwise could not afford the expense of treating himself outside a hospital would find in this simple and cheap remedy a considerable advantge.—*Med. Press*, April 23, 1890.

Taylor (J. M.) on the Best Way to Use Sulphonal.—As a motor depressant the author gives 5, 7, or 10 grains of sulphonal after food twice or thrice a day. As a hypnotic the same dose, beginning early in the afternoon, at intervals of two hours, and continue until two hours before sleeping time ; say 4, 6, and 8 P.M. If this method is not effective then begin at 2 or add two grains to each powder. The author gets better results from divided doses than from the same amount in a single dose.—*University Med. Mag.*, May, 1890.

Kelly (L. A.) on Chloroforming the Sleeping.—Some two years ago I had occasion to remove a piece of catheter from the bladder of a young man, fifteen years of age. The accident happened in the morning, and I arrived at the place about midnight of the same day, to find the patient sleeping soundly and sweetly, having been asleep for fully two hours.

The subject and his necessity seemed to warrant the propriety of an experiment, if such it may be called. Without awaking him, I began to administer chloroform in the usual way. Much to my surprise, sleep continued undisturbed by the anæsthetic, not the slightest movement of limb or muscle indicating consciousness. The breathing only was slightly affected, as the sleeping passed from natural to the artificial.

The operation concluded and the chloroform suspended, he was aroused with some effort by his friends. This subject had not suffered previous loss of sleep, and presented no evidence of previous exhaustion or ill-health.—*Med. Record*, March 29, 1890.

Wormley (T. G.) on Recovery of Absorbed Morphine, from the Urine, the Blood, and the Tissues.—The author has determined that organic liquids and solids yield their contained morphine to amylic alcohol better than to any other solvent. The presence of organic compounds, especially urea, impair to a slight extent the delicacy of the test, boiling in the open air removing, to a certain extent, this complication.—*University Med. Mag.*, May, 1890.

The Toxic Effects of Cannabis Indica.—Not long ago, for neuralgia, I took forty drops of the tincture of cannabis indica. The neuralgia was soon forgotten, and in about an hour's time I began to feel giddy, full in the head, and very faint, and soon experienced a sensation of heaviness and numbness in the feet and legs, followed by partial anæsthesia, gradually extending upwards to the knees. My feet and legs felt as if enormously swollen and thickly covered over with wool. Soon the loss of sensation became complete as far as the knees ; walking was then impossible, and even standing a difficulty. Shortly similar symptoms appeared in the upper extremities, commencing at the finger-tips, and extending as far as the elbows. The anæsthesia was not so complete as in the lower extremities. During this time there was great anxiety and fear of death through cardiac paralysis, which seemed almost imminent. The

heart's action was tumultuous and irregular. On the return of sensation to the extremities, I was possessed with an almost irresistible desire to commit suicide by rushing into the adjoining canal or cutting my throat with the knives on the table close by, though no attempt was made at doing so. Shortly upon this I was seized with fits of alternate laughter and crying, without any apparent cause. When the symptoms were subsiding, my appetite became ravenous, accompanied by great thirst scarcely to be appeased, and then sleep intervened. The following morning I awoke, after a very sound sleep and a good night's rest, determined never again to take cannabis indica, and be most careful in prescribing it for others. I may state that I experienced no pleasurable intoxication or feeling of happiness, but the very reverse.—An anonymous writer in *Lancet*, March 15, 1890.

Kingsbury (G. C.) on Rapid Cure of Erysipelas by Ergotine.—For erysipelas, like most other painful diseases, hosts of remedies have been suggested, and ever since Hueter discovered cocci in this particular ailment, all sorts of germicide applications have been tried, with and without success. The most recent favorites are carbolic acid, ichthyol, and creolin. Without wishing in the slightest to underestimate the value of these agents, I would like to call attention to what has been my invariable treatment for at least five years. In every case I have used ergotine applied with a camel's-hair brush to and around the affected area, and have found it a painless, rapid, and almost certain cure; in fact, I cannot recall a single case in which it has disappointed me. It is best used in the form of a 50-per-cent. solution in distilled water, painted on frequently. Generally one or two applications suffice to diminish all feeling of tension, and it is rarely that the pain is not quite conquered in twenty-four hours, leaving the patient comparatively well. In many cases I have relied solely on the ergotine, not prescribing any internal medicine.

In writing this note I have no desire to be thought original, for I saw the treatment recommended in some medical paper of about the year 1884 or 1885, but I cannot lay my hands on it now, and fear the treatment has not had a fair trial, as I never hear of its being adopted. Neither do I pretend to explain the action of the ergotine, but the effective way in which it cuts off the excessive blood supply to an overvascular area, naturally suggests its trial in other passive congestions, and in these also I have found it very useful.—*Brit. Med. Jour.*, March 15, 1890.

The Comparative Action of the Iodides of Potassium and Sodium.—At the last meeting of the Academy of Medicine Dr. Laborde read a very interesting note on the comparative action of the iodides of sodium. He pointed out an error now very prevalent in therapeutics—in considering isomeric substances as possessing the same physiological and therapeutical properties as their congeners. It is thus, for instance, that chlorate of potassium has been replaced by chlorate of sodium, iodide of potassium by iodide of sodium, etc. On the same grounds it was supposed that bromide of potassium might replace iodide of potassium in the treatment of syphilis, but the attempt was eminently unsuccessful. It was also thought preferable to administer chlorate of sodium in stomatitis, because it is more soluble than chlorate of potassium, whereas a more attentive examination would have shown that, while a solution of chlorate of potassium destroys in a short time false membranes, a solution of chlorate of sodium does not act on these morbid products. It was also thought that the alkaloids of the same family could be administered indifferently, those of cinchona, for example, whereas experiment shows that quinine has no action upon the nervous centres, whilst cinchonine and cinchonidine provoke attacks of epilepsy. It has also been proposed to administer to certain patients iodide of sodium in the place of iodide of potassium. Dr. Laborde opposed this theory, and recalled that Professor Germain Sée had long ago shown the difference of action between these two salts on the blood pressure, which is augmented by iodide of potassium, whereas iodide of sodium scarcely modifies it. These facts were already established, and he wished to find an explanation of them. He therefore experimented on non-curarized animals, and ascertained that iodide of potassium produced general tetanus, whereas experiments with iodide of sodium, even in double quantities, produced negative results. Iodide of potassium excites the nervous centres, whence its action on the vascular system and on the heart. Dr. Laborde

concluded his paper by impressing on his hearers that chemical analogies could give no just appreciation of effects on the organism, and that physiological experiment alone would enable one to establish clearly the indications for the therapeutic employment of divers drugs sometimes almost similar chemically, and yet very different from a physiological and therapeutical point of view.—*Lancet*, March 15, 1890.

Edgar (C. J.) on Iodoform in Chronic Cystitis. — Having on hand several cases of decidedly chronic cystitis, which did not show satisfactory signs of improvement under ordinary treatment, I decided to treat one half the cases (three) with the iodoform injections. The bladder was first washed out with moderately hot water, as usual, and then an injection of the following emulsion made :

Iodoform	ʒ x.
Glycerine	ʒ i.
Tragacanth gum	gr. i.
Distilled water	ʒ ii.

Sig.—One tablespoonful to a pint of lukewarm water, well stirred, for one injection—injection made every second day.

The first part of the mixture was injected and held about half a minute, until the iodoform had settled, and was then allowed to come away clear. The latter part was ordered to be retained as long as possible without pain.

The day after the first injection, the patients all agreed in finding micturition less difficult, less painful, and much less frequent. They had all noticed also that the urine had deposited a yellow sediment —the iodoform. The effect of the second injection was still more marked, and the third injection completed the cure, leaving them perfectly free from any symptoms whatever of their trouble. The remaining three cases were then put on the same treatment, with the same result, excepting that the two worst cases required five injections before they confessed themselves quite cured. Of these cases three were gonorrhœal, one from cold, and two cause unknown, and had all been under medical treatment for periods ranging from six months to three years. The treatment in these cases was alike for all, independent of their causation.

I have not had the opportunity of testing the use of this drug as an injection in other affections of the bladder, but certainly in the cases mentioned, and occurring in both sexes, its action was most satisfactory.—*Montreal Med. Jour.*, Jan., 1890.

REPORT ON CUTANEOUS AND GENITO-URINARY DISEASES.

BY CONDICT W. CUTLER, M.D.

Cutler (Condict W.) on Nævus Neurotica.—Dr. Cutler gives the history of a case of ichthyosis linearis neuropathica or nerve nævus as follows: The patient was a boy, five years of age, born in Italy. When six months old, there appeared, just behind the inner malleolus of the left foot, a hard, scaly ridge, which gradually extended along the inner side of the foot and up the leg until, at the end of a year, it reached its present dimensions. As it appears at present the lesion begins abruptly at the left buttock just opposite the great sacro-sciatic notch, and follows down the course of the great sciatic nerve, the internal popliteal nerve, the post-tibial nerve, and the internal plantar nerve to the great toe. A second lesion, beginning on the left buttock just to the inner side of the other, follows very closely the course of the small sciatic nerve for about three inches. These lesions are elevated about two lines and are about seven lines in width. They are very scaly, the scales being quite small and firmly attached. The child's health is very good, and with the exception of some itching, the disease does not seem to cause the child any uneasiness.—*Jour. of Cutaneous and Genito-Urinary Diseases*, April, 1890.

Hartzell (M. B.) on Recurrent Herpes Zoster.—Recurrent herpes zoster differs from the simpler forms in many particulars. It is usually followed by superficial cicatrization. The severe neuralgic pains are always preceded for a day or two by intense burning sensations. The arrangements of the lesions are peculiar, in that they are grouped in a circinate manner, and first appear over the peripheral nerve branches and extend toward the centre, which is contrary to the usual course. In a large proportion of all cases of recurrent herpes zoster an injury of some kind has preceded the appearance of the disease, and is probably an exciting cause.

From the foregoing brief analysis it is quite evident that recurrent herpes zoster is in many respects, apart from the feature of recurrence, markedly different from the ordinary type, such as is seen, for example, on the side of the thorax, over the course of the intercostal nerves. The repeated attacks, together with the unusually large proportion of cases in which the eruption is bilateral, point to lesions centrally situated, which have produced more or less profound disturbance of trophic centres.—*Amer. Jour. Med. Sciences*, April, 1890.

Unna on Paquelin Cautery in Dermatoses.—Unna recommends the use of the Paquelin cautery in the following dermatoses: In chronic eczema ani, which resists other treatment. Eczema scroti et vulvæ, leucoplakia oris, angioma oris. His mode of application is thus: Local general anæsthesia is produced, and with a broad Paquelin's burner slowly cauterizes the affected parts, so that, were the proper remedies not applied immediately, a burn of the second degree would result. Before the anæsthesia is over, apply a 5 % solution of borax, with or without cocaine, carron oil, to which a 2 % carbolic acid is added, or resorcin solution.—*Canada Med. Record*, March, 1890.

Schenck (W. L.) on Pruritus of the Vulva.—The following prescriptions will be found to be very useful in the treatment of pruritus vulvæ:

Dr. R. W. Taylor extols the following narcotic lotion:

℞ Fol. belladon., fol. hyoscyami . aa. ʒ ij.
Fol. aconit. . . . . ʒ ss.
Acidi acetici . . . . . fl ℥ i.
M. Macerate, filter, and add an equal part of glycerine.

Dr. Shoemaker recommends the following:

℞ Ung. hydrarg. nitratis. . ʒ iijss,
Hydrarg. oxidi rubri . . grs. xx.
Adipis . . . . . ʒ iv. M. Ft. ung.

℞ Acidi cabolici . . . . ʒ ss.
Chloral hydrat. . . . . ʒ j.
Glycerini . . . . . ʒ j.
Aquæ camphoræ . . . ℥ ijss.
M. Ft. loti. SIG.—Apply externally.

Dr. Lombe Athill applies between the labia cotton saturated with the following:

℞ Acidi carbolici . . . . grs. xx.
Tr. opii . . . . . ℥ ss.
Acidi hydrocyanici dil. . ʒ ij.
Glycerini . . . . . ℥ ss.
Aquæ . . . . q.s. ad. ℥ iij.

℞ Hydrarg. bi-chlorid. . . grs. ij.
Acidi carbolici . . . . grs. x.
Aquæ camphoræ . . . ℥ j.
Alcohol . . . . . ℥ j.
M. SIG.—Apply as a lotion.

℞ Acidi carbolici . . . . grs. xx.
Tr. opii. . . . . ℥ ss.
Acidi hydrocyanici dil. . ʒ ij.
Glycerini . . . . . ℥ ss.
Aquæ dist. . . . ad qs. ʒ jv.
M. SIG.—Saturate a piece of absorbent cotton, and apply between the labia.

—*Kansas Med. Jour.*, April 20, 1890.

Ohmann-Dumesnil on Antipruritics.—Antipruritics are a class of remedies of the highest importance in the treatment of diseases of the skin. They secure rest and immunity from itching and lessen the amount of scratching, which is sure to bring on secondary lesions of the skin, thickening and pigmentation. Another advantage derived from antipruritics is a relief from nervous irritability and the avoidance of hypnotic remedies and narcotics.

Unfortunately we have no antipruritics which can be with any degree of certainty relied upon. In some instances one will act where another is a total failure, so that tentative efforts must be frequently made. Among the most commonly used antipruritics are: dilute carbolic acid, menthol in solution, weak alkalies, dilute alcohol, dilute hydrocyanic acid, tarry preparations, etc. Solutions of cocaine, morphine, camphor, etc., or combinations of the same are also frequently of service. When the surface of the skin is broken some little caution is requisite not to employ such antipruritics as are caustic in their action.—*St. Louis Clinique*, Feb.. 1890.

Piffard (H. G.) on Pemphigus Pruriginosus.—Dr. Piffard in the *Journal of Cutaneous and Genito Urinary Diseases* describes under the term pemphigus pruriginosus a rare form of disease which would undoubtedly be claimed by Duhring as an example of dermatitis herpetiformis.

The writer has met with perhaps half a dozen cases to which he has applied the name pemphigus pruriginosus for lack of a better one. These cases presented the common features described by the older writers—namely, small bullæ, scratch-marks, a hyperpigmentation accompanied with severe pruritus, and, according to the length of time the affection had lasted, with more or less depression of the nervous system. The disease is in no way related

to the ordinary forms of pemphigus.—*Jour. of Cutaneous and Genito-Urinary Dis.*, April, 1890.

Lydston (G. F.) on Herpes Progenitalis in Relation to Syphilis.—Very little mention has ever been made by writers of the possible causal relation of syphilis to herpes progenitalis. On this subject Dr. Lydston remarks as follows:

I am convinced, however, from practical observation and experience, that many cases are directly dependent upon the syphilitic cachexia. I find quite a number of my syphilitic patients returning to me from time to time, with apparently typical crops of herpes upon the genitalia, which are obstinate to all local measures excepting the application of mercurials. Tonic and mild anti-syphilitic remedies are also required internally. I attribute the herpes in such cases to several causes:

First. (In some cases) local irritability incident to a pronounced chancre or mixed sore which has initiated the patient in his venereal trouble.

Second. Disturbed innervation and consequent trophic changes, incidental to the effects of the syphilitic poison, excessive medication, (especially with mercury) and mental worry, upon the sympathetic system.—*Med. News*, Feb. 8, 1890.

Ohmann-Dumesnil on Herpetiform Chancre.—The herpetiform chancre is so named from its close resemblance to the lesion of herpes progenitalis. The importance of not confounding it with herpes will be recognized and the difficulty is sometimes quite marked. There exists a chancriform herpes in which an induration, analogous to that of the chancre, is present. It is in such cases that the diagnosis between herpetiform chancre and chancriform herpes becomes of the greatest importance both to the physician and his patient. The history of the lesion is not of much value, in the majority of cases. The feel can perceive no difference in the induration, so that we are left to rely almost entirely upon one distinction. In the herpetic trouble, if the lesion be squeezed between the thumb and forefinger a drop of serous fluid will ooze out. If the same operation be repeated in three or four minutes another drop will appear, and this may be repeated for a number of times. In the case of the chancre, the first attempt of the kind will produce a similar drop, but subsequent attempts will prove futile. The cause of this is that herpes is an exudative disease, while the chancre is neoplastic. By remembering this the distinctive feature alluded to will not be easily forgotten.—*St. Louis Clinique*, Feb., 1890.

Skottowe (A. J. F.) on Frambœsia or Coko.—This disease is very common in the Fiji Islands. It is very common among children, it being a common superstition among the people that if their offspring do not develop "coko" in childhood, they will grow up weak and delicate; and they believe, further, that the affection prognosticates the health and strength of adolescence. So implicit is their faith in these conceptions, that if their children do not incur the affection, it is often produced by inoculation.

It is highly contagious, both sexes suffering equally, attacks all ages, but as one attack protects against a second, the disease among the natives is almost confined to children.

As seen in Fiji, the eruption consists of tubercles elevated a third of an inch or more above the surface, and varying in size up to several inches in diameter, rough superiorly, of a dull yellowish color, with some tendency to bleed, and moist from a thickish, usually scanty, but sometimes plentiful discharge.

In the majority of cases the tubercles are by no means numerous, and are found on the face, chest, abdomen, genitals, and the inner aspect of the limbs; sometimes they are abundantly developed, occasionally scattered over the whole body. Usually the tubercles are distinct and well defined. but when developed on their favorite situation—*i. e.*, where skin passes into mucous membrane, as round the apertures of mouth, nostrils, eyes, vagina, or anus, the tubercles coalesce and form considerable tracts—in many cases completely surrounding the orifices, but this is especially seen where the underlying tissues are soft and lax, as in the lips, anus, or vulva.

The constitutional symptoms seem to vary with the extent of the cutaneous implication and the duration of the disease. There is usually anorexia, anæmia, and great loss of flesh and strength. The disease lasts for months, and leaves cicatrices the result of the destructive skin-lesions.—*Glasgow Med. Jour.*, March, 1890.

Hoffman (R.) on Traumatic Alopecia Areata.—Alopecia areata is usually considered as the result of either trophoneurotic

influences, or of parasitic infection ; injury, however, may be the direct cause of the disease, which could be directly traced in several instances.

Joseph's experiments, who caused loss of hair in circumscribed spots on the head of cats by section of the spinal ganglion of the second cervical nerves, equally has some bearing on traumatic cases. Leloir, who reports over ninety cases, found that three of them were caused by traumatism. —*Maryland Med. Jour.*, March, 1890.

Taylor (R. W.) on Treatment of Scabies.—The following is Dr. Taylor's plan of treatment of scabies : The patient is to soak himself thoroughly in a bath at 100 ° F., in which there has been dissolved one pound of washing soda, and while in the bath he is to rub himself thoroughly with some good soap that makes an abundant lather. Having dried the surface, he is to rub in the following ointment :

℞ Balsam. Peruviani
Lac. Sulphuris . . . . āā ʒi
Vaselini . . . . . ʒi
M.

This is to be left on all night. He should have ready clean bedding and clothes. There is no necessity for internal treatment, but drinking liquor of any kind should be avoided, as it increases the irritability of the skin.—*St. Louis Med. and Surg. Jour.*, April, 1890.

Ohmann-Dumesnil on Treatment of Sycosis.—When the curative portion of the treatment is undertaken, epilate as thoroughly as possible. Where a large area is involved this cannot be done at once, but will have to be performed at successive daily sittings. Care must be taken to epilate thoroughly, and the vibrissæ in the nostrils should not be overlooked. Not only is this epilation to be faithfully carried out, but such pustules or small abscesses as exist should be opened and their contents evacuated. When hairs are extracted the pus contained in the follicle should be evacuated as much as is possible. In regard to the tubercular infiltrations, when such exist, pay no attention to their treatment, as they disappear in a short time under the effects of the medication employed. As soon as the last hair of that sitting has been extracted apply camphophenique pure, and order the patient to make a similar application at night. This simple treatment constitutes the curative portion.

After a variable length of time it will be observed that pustules are very unusual lesion, and it is then the proper time to institute the prophylactic portion of the treatment. This is absolutely essential for two reasons. In the first place, a few microorganisms may be deeply lodged in some crypt ; and, if the patient is permitted to neglect all treatment, they will constitute a focus, from which a general infection will spread, and a consequent relapse of the disease will occur. In the second place, the omission of any treatment exposes the patient to the dangers of a fresh infection from without. Having had sycosis once shows a susceptibility to the disease, which is increased by the fact of having contracted it. For these reasons a patient, who is apparently cured, should be subjected to a further course of treatment. The prophylactic course is very simple. Order the patient to shave every morning. He is directed to make his lather with a bichloride of mercury soap, using a 1 in 1,000 bichloride solution in water. He is also cautioned to render aseptic his razor, shaving-brush, etc., by some simple means. After having shaved, a bichloride solution is ordered to be applied, the strength varying from 1 in 500 to 1 in 1,000, according to the tenderness of the skin. At night the same application is made or sometimes varied by ordering lanolin to be rubbed in. In ordinary cases a cure may be expected in a month or two. In long-standing cases the tubercular masses disappear under the influence of campho-phenique, which is antiseptic and reducing.—*St. Louis Med. and Surg. Journal*, March, 1890.

Vidal (M.) on a New Treatment of Tinea Tonsurans.—M. Vidal (*Gazette Hebdomadaire de Méd. et de Chirurgie*, July 26, '89) advocates one which has for its object the destruction of the tricophite by microbicides and the prevention of its reproduction by depriving it of its oxygen, for, as is well known, this is an ærobic organism. The technique is as follows : (1) Application of lotion of spt. turpentine to the scalp without previous epilation. (2) Friction with tr. iod., which should at each sitting be applied only to a limited surface of the head. This should be repeated two or three times for each spot, until it has been applied to the whole scalp. (3) Daily inunction of the scalp at intervals with vaseline. (4) Covering the head with a rubber cap, which should fit as

closely as possible to the head. It is claimed by this method epilation is avoided and duration of disease shortened.—*Canada Med. Record*, March, 1890.

Harrison (J.) on Treatment of Tinea Capitis.—Dr. Harrison recommends the following treatment for tinea capitis, which he claims has been very successful in his hands. He claims that the reason of this success is due to softening the follicles and the sebum surrounding the hair, and thus facilitates the entrance of the parasiticide and its direct contact with the hair. The method consists in cutting the hair short and rubbing in, morning and evening, a quantity about the size of a pea of the following ointment:

℞	Acid. carbolici . .	3 parts.
	Potassæ caustic . .	1 part.
	Lanolin,	
	Butyr. ciacao . . .	āā 50 parts.
M.		

A cure follows in at least two or three months. The method is certainly a very simple one and should become popular if it accomplishes its purpose.—*St. Louis Med. and Surg. Jour.*, April, 1890.

Ransome on Resemblance of Phthisis and Leprosy.—Baumgarten states that it is impossible to distinguish by the microscope the tubercle from the leprosy bacillus. However true this may be, inoculation experiments show an absolute diversity and give no support to the idea that there is a bacillus common to both these diseases.

The tubercle bacillus can be grown and regrown for many generations in certain media. Pure cultivations can be inoculated with certain success in animals, but this has never yet been accomplished in the case of the leprosy bacillus. Köbner, Campana, Thin, Neisser, Damsch, and Bizzozero have, in a series of carefully arranged experiments, attempted to inoculate the leprosy bacillus in animals, but have always failed. There can, therefore be no doubt that these bacilli are specifically distinct.

Dr. Ransome points out clearly other points of difference in connection with the changes they produce, the chronicity of leprosy lasting from ten to twelve years, contrasting with the three or four years which is the average in the case of phthisis. Indeed, the points of difference between the two bacilli are even more striking than their resemblance.—*Brit. Med. Jour.*, March 8, 1890.

Heller on a Case of Mixed Infections (Dermatitis Tuberculosa Acuta).—Heller, of Kiel (62. Versammlung deutscher Naturforscher zu Heidelberg, 1889), described a peculiar skin affection in a child four months of age, the subject of general miliary tuberculosis originating from cassous glands adherent to the right innominate vein.

The eruption on the skin consisted of fine red points and papules, vesicles and bullæ, the latter containing partly clear, partly cloudy and bloody contents; in the neighborhood of this eruption, from the bursting of the vesicles, small ulcerations with a yellowish base and a central gangrenous spot extending somewhat deeply. The vesicles contained tubercle bacilli.

Skin sections taken from different places showed small round-cell infiltration with imperfect staining of the cell nuclei in the central portion of the papule.

A few tubercle bacilli were found in the sections, together with numerous small micrococci; the cocci were found not only in the papules, but also, much less abundantly, however, in the healthy skin and in the division of a small artery.

The author believed that, as in other parts of the body, the tubercle bacilli which had gained entrance into the circulation had produced a secondary tuberculosis of the skin; that it would, however, have remained unobserved had not the advent of the micrococci caused development of the eruption.—*Jour. Cutaneous and Genito-Urinary Dis.*, Feb., 1890.

Ostermeyer (E.) on Anti-Parasitic Ointments.—Dr. Ostermeyer claims that the following ointment is the best formula for use in all skin affections dependent upon either the animal or vegetable parasites:

℞	Salicylic acid . .	3.0	parts.
	Borax	1.0	"
	Bals. Peru . . .	2.0	"
	Vaseline	20.0	"
	Ether. essence anis.	gtts. v.	"
	Essence bergamot .	gtts. xx.	" M.

—*Jour. Cutaneous and Genito-Urinary Dis.*, Feb., 1890.

Ohmann-Dumesnil (A. H.) on Ointment Bases.—Ordinarily the object of ointment bases is to mechanically suspend some active agent, which is to be applied

to the skin. In such cases it is always desirable to have for a base a combination which is neutral in its effects while, at the same time, it is more or less protective. The unguentum aquæ rosæ is a good representative of this class, as is also benzoated lard. An ointment base which is but little known and used in this country is one which makes an elegant preparation and known as unguentum pomadini. Its formula is as follows :

℞	Olei cacao	ʒ 1.
	Olei amygdalarum	ʒ 2.
	Olei rosarum	q. s. ♏.

—*St. Louis Clinique*, Feb., 1890.

OCCASIONAL REPORT ON INSANITY AND NERVOUS DISEASES.

BY FREDERICK PETERSON, M.D.

Clouston (T. S.) on Morphinomania.—The following is a brief summary of an interesting article in the *Edinburgh Med. Jour.*, March, 1890 :

1. The habitual use of opium is in nine cases out of ten most injurious to the higher mental powers, and more especially impairs the volition.

2. The dose has to be steadily increased till such an amount is taken as tends to impair nutrition and the trophic energy of the brain, to disturb the appetite and the whole alimentary system, and ultimately to destroy the power of natural sleep.

3. The craving set up by such excessive use of opium is one of the most persistent, intense, and difficult to resist of any known morbid cravings. It has no remission or periodicity in it.

4. The nervous constitution of the patient has very much to do with the inception of the habit. It may be said generally that persons of the nervous diathesis, of nervous or insane or drinkers' heredity, all persons who feel and dread pain excessively, and most "excitable" persons, are specially liable to acquire the craving.

5. Given or taken for insomnia or to relieve pain, is the origin of most cases of morphinomania.

6. It behooves medical men to take the constitution of each individual patient carefully into consideration before opium is prescribed, and to ask : "Is there any danger of a habit being set up ?"

7. As to the treatment of morphinomania, I have but little hesitation in laying down its principles : Help from without in the shape of skilled strong nursing ; control and never-remitting companionship are needed in almost all cases. It is better and safer to undergo the short Hades of absolute stoppage than the more prolonged purgatory of tapering off. While this is being gone through, use the bromides, wines, every form of beef and peptonoids that the stomach or the rectum will retain ; bismuth, ice, and counter-irritation for the gastric pain and vomiting ; digitalis and strophanthus for the weak and irregular heart's action. I should now use paraldehyde or sulphonal to get some sleep for a few nights, but I should not go on for long with them. If there is emaciation, I should try Dr. Playfair's recommendation of massage, though I suspect some of the good effect in his cases resulted from the control of the massage nurses, and the taking up of the patient's mind by the details of the process, and the assertions that would be dogmatically dinned into their ears as to its unfailing efficacy. The great things to aim at are good nerve tone, firm muscles, a brown sunburnt skin, steady occupation, as much fat as can be put on, a sound moral sense all round, strengthened inhibition, and a dominating conviction that the drug is poison in any dose, and under any possible circumstances whatever.

Clouston (T. S.) On Cocainism.—The chief facts about cocaine in relation to cocainism may be thus summarized :—

1. It is the acutest and the most absolute destroyer of inhibition and of the moral sense generally that we yet know.

2. The morbid craving is very intense and control is absent.

3. The dose requires to be increased faster than that of any such drug to get the same effect.

4. The delirium and hallucinations of all the senses of single doses become chronic in cocainism.

5. Its immediate effects are more transient than any other such drug, but this does not apply to the craving set up.

6. The treatment of cocainism consists in outside control of the patient, in stopping the drug at once, in careful watching —I should not trust a patient under treatment as regards suicide for the first week, —nursing, the use of every sort of food that will keep up the strength, and of the

bromide of ammonium, brandy or wine, tea and coffee, and possibly an hypnotic, like paraldehyde or sulphonal, for two or three nights at least.

7. A patient suffering from cocainism can usually be certified as insane so far as the presence of delusions is concerned, but he gets over these so soon, and yet is so far from the real cure, that certification and sending to an asylum is not a satisfactory process altogether. We need cocainism included in any special legislation for dipsomania.—*Edinburgh Med. Jour.*, March, 1890.

Mabon (Wm.) On Chloralamide as a Hypnotic for the Insane.—The author used the drug in treating cases suffering from various forms of insanity and summarized the results as follows after the administration of one hundred and thirty doses of twenty to sixty grains each. Twenty grains were given twice and they produced an average sleep of three and three-quarter hours. Thirty grains administered fifty-one times averaged five hours' sleep. Seventy-four doses of forty-five grains procured sleep which averaged four and two-fifths hours. Average of sixty-grain doses given three times was three and five-sixths hours. General average was four and three-fifths hours.

In the successful cases thirty-grain doses seemed to give the most satisfactory sleep. The time required to induce sleep varied from fifteen minutes to five hours, and in character it was with few exceptions light and restless.

In one case nausea and incoördination were produced; in another vomiting; in another some confusion and incoördination; and in still another vertigo.

He finally concludes that sulphonal and chloral are much more advantageous as hypnotics in insanity than chloralamide.—*Am. Jour. Insanity*, April, 1890.

Absence of Knee-Jerks in Complete Transverse Lesions of the Spinal Cord.—Hitherto considerable reliance has been placed upon spasticity and exaggerated knee-jerks as evidence of transverse lesions of the cord above the lumbar enlargement, but it seems that our views are to suffer a complete reversion on this point. Feb. 22d last, Dr. Bastian presented a paper at the meeting of the Royal Medical and Chirurgical Society in support of his opinion, expressed eight years ago, that in *complete* transverse lesions of the cord above the lumbar enlargement, all the deep reflexes are absent and the limbs flaccid instead of rigid. The *Lancet* of March 8, 1890, speaks editorially of his paper and the discussion upon it as follows:

"In support of his contention he gave minute and accurate clinical records of four cases in which there was developed, under observation, complete transverse lesion of the spinal cord (in these cases due to extensive softening). At first the deep reflexes were exaggerated, but as the lesion became more and more complete, as shown by absolute motor and sensory paralysis, the deep reflexes entirely disappeared, and the limbs became completely flaccid. This condition of things continued until death, when the necropsies showed (at any rate in three cases) complete destruction of the cord at the level of the lesion. In these cases shock was out of the question, the lesion was in the upper part of the cord, and there was not the slightest evidence of any independent lesion in the lumbar enlargement. Dr. Bastian fortified his position by quoting nine cases of fracture-dislocation in the cervical and upper dorsal regions, in which flaccidity of the limbs and abolition of the reflexes were noted soon after the accident, and persisted until death occurred, in most cases weeks later, when all shock had long passed away. It is much to be regretted that fuller opportunities could not be afforded for discussing so important a communication; but in the brief discussion which followed on these points additional cases were quoted by Dr. Hughlings Jackson and Mr. Bowlby, completely confirming the views expressed in the paper. Dr. Bastian looks with suspicion on the cases which have been described as complete lesions due to compression of the cord in Pott's disease. A case will be found in our issue of Feb. 22d, in the report of the meeting of the Pathological Society, in which for twelve months before death there had been absolute paralysis of motion and sensation, but in which there was rigidity and increased reflexes. Here, to the naked eye, the disorganization of the cord at the level of the lesion appeared to be complete; but careful examination by modern methods showed the existence of a considerable number of axis-cylinders traversing this apparently disorganized portion of the cord, so that this case, and probably also

those referred to by Dr. Buzzard in the discussion, would hardly come under the category of *complete* lesions to which Dr. Bastian's paper refers, and with regard to which he completely established his case.

"Another point of interest, from a clinical point of view, was the different behavior of the superficial and deep reflexes. In all of Dr. Bastian's cases, after motility, sensibility, and deep reflexes were completely abolished, the plantar skin reflex persisted for a short time. Mr. Bowlby also had observed that in the cases of fracture-dislocation, some weeks after the accident the skin reflexes returned, while the deep reflexes remained absent until death. Of not less interest than these clinical observations were the remarks made by Dr. Bastian as to their bearing on the theories with regard to muscular tone and the deep reflexes. He held that these cases showed that the tone of the muscles and the presence of the knee-jerk depended on influence passing down from the encephalon, favoring these reflex phenomena. This influence was thirteen years ago attributed, on theoretical grounds, to the cerebellum by Dr. Hughlings Jackson, and to his view, with some modifications, Dr. Bastian adds his support. Dr. Jackson believes that the normal tone of the muscles is due to the balance of influences constantly passing down from the cerebrum and cerebellum, the former tending to diminish and the latter to increase the tonus of the muscles, and in this way accounts for the increased reflexes in cases of hemiplegia, the cerebral influence being cut off and the cerebellar influence no longer interfered with. There is evidence that this cerebral influence descends by the pyramidal tracts, and, assuming that these authors are correct in their views, it seems probable that the cerebellar influence descends in the gray matter. This is supported by the occurrence of increased reflexes in the cases of slow compression, where the gray matter is usually less damaged than the white, and by a case of Mr. Thorburn quoted by Dr. Bastian, in which there was hemorrhage almost confined to the gray matter in the cervical region, in which the absence of deep reflexes persisted, although the conducting functions of the white columns were to a considerable extent restored. Now that the matter has been so prominently brought before the profession, we may expect that facts will soon be forthcoming to settle definitely some of the disputed points to which we have referred."

Ritchie (James) on a Case of Epileptiform Neuralgia.—At a meeting of the Royal Medical Society of Edinburgh, January 17, 1890, Dr. Ritchie described the following case: The patient, a man of 50, came under the care of Professor Chiene in the Royal Infirmary, Edinburgh, early in June, 1889. He complained of paroxysmal pain, accompanied by spasms in the right side of the face. The pain began fifteen years ago, its first situation being the right side of the lower jaw. From the first it was paroxysmal, coming on every quarter of an hour, and as frequently by night as by day. No cause could be assigned to the onset of the pain, and as medicinal treatment proved ineffectual, all the right lower molars and premolars were removed shortly after its commencement. This, however, did no good; the pain increased in severity and spread to the upper jaw, and about two years after its first appearance began to be accompanied by spasms of the right side of the face. During succeeding years the pain spread to the right temporal region and to the front of the right ear, and though there was an occasional temporary improvement in the symptoms, no permanent good resulted from any medicinal treatment. On admission the patient was found to suffer the greatest agony from paroxysms of pain, which occurred every two or three minutes during the day, and every half hour or so during the night. The paroxysms began and were most severe in the regions supplied by the inferior dental nerve, and spread to those supplied by the infra-orbital, nasal, supra-orbital, and temporal branches of the fifth nerve. They were accompanied by a tonic, succeeded by a clonic spasm of the right facial muscles. They came on while the patient was quite quiet, but also during mastication and articulation. There was no hyperæsthesia, and sensation was equal on both sides of the face. No cause could be discovered to account for the condition; the patient had always been healthy, and no neurotic taint seems to have existed in his family. There was, further, no history of syphilis. On June 10th Professor Chiene trephined the lower jaw below the sigmoid notch, and removed about half an inch of the inferior dental nerve, as it was in it the pain first commenced. The patient left the hospital

on June 15th with the wound healed by first intention, and from the date of operation up to the present time has had no return of the pain or spasms.—*Edinb. Med. Jour.*, March, 1890.

Tedeschi (G.) on Massage in Lead Palsy.—In the *Giorn. intern. delle scienze med.*, 1889. Fasc. 6, this author describes a case of lead palsy with atrophy and contracture in the upper extremities, of three years' standing, which he cured completely in three months by means of massage to the muscles according to Metzger's method. At the beginning of the treatment he found a simultaneous elimination of lead in the urine, which gradually increased in quantity as the treatment was continued. Previous to the use of massage repeated examination had failed to detect the presence of lead in the urine.—*Centralbl. für klin. Med*, Feb. 1, 1890.

Schmidt (C.) on Codeia in the Treatment of Morphinism.—The author uses a 10 % solution of codeia subcutaneously in the treatment of morphine habitués, the morphine having been altogether withdrawn. According to his experience codeia has more particularly a spinal than a cerebral action, and as it induces no euphoria, it is itself incapable of causing a habit.—*Deutsch. medicin. Woch.*, Jan. 23, 1890.

Eulenburg on Diminished Electrical Resistance as a Positive Symptom in Basedow's Disease.—Professor Eulenburg has made careful measurements of the electrical resistance in 28 cases of exophthalmic goitre. The general conclusions, reached by him may be summarized as follows :

A relatively low resistance, between 1,000 and 2,000 ohms, obtained by the use of a small voltage (10 Siemens elements), although not a constant accompaniment of Basedow's disease, is still very frequently found.

It may be taken as a general rule in the diagnosis of exophthalmic goitre that the presence of the characteristically diminished electrical resistance is a valuable positive symptom. Its absence, however, has no particularly negative significance.—*Centralbl. für klin. Med.*, Jan. 4, 1890.

Gordon on Paraldehyde in Inebriety.—Professor Gordon, of the University of Aberdeen, writes as follows upon this subject :

" As an hypnotic in all cases of cerebral disease and nervous irritability, its action was prompt and prolonged ; no stage of excitement, and no headache, depression, or indigestion followed its use. While it diminished the frequency of the heart's contractions, it seemed to strengthen the beats. It is not a cardiac depressant. It has no marked period of toleration, and has been given for months with equally good results. No marked craving for the drug has ever been noticed from its long use. In many cases it is a laxative for the bowels. An increased secretion of urea follows its use. It does not have any effect on the temperature. The reflex excitability of the spinal cord is rapidly diminished. The peripheral nerves are also markedly controlled, and the motor nerves are influenced profoundly. In large doses, complete narcotism of the nervous system follows. From this it will be clear that as a narcotic, when alcohol or opium is taken away, it has a peculiar value. At present the use of it is difficult, in persons who have a sensitive stomach and some art is required to disguise it so as to be palatable. Paraldehyde comes very near being a perfect remedy for the insomnia and neuralgia that follow the withdrawal of opium and alcohol.—*Quart. Jour. Inebriety*, April, 1890.

Oppenheim and Siemerling on Hyptrophied Muscular Fibres Removed during Life.—Oppenheim and Siemerling call attention to the fact, which they think has not heretofore been noticed, that muscular fibres removed during life are, on the average, from twice to three times as thick as those removed *post mortem*—a circumstance for which they are wholly unable to account. In the following number they give the rather obvious explanation, suggested by Professor Zuntz, that the difference in size is due to the contraction of the living muscle after excision. The fact is one which should be borne in mind by those engaged in such investigations. —*Centrabl. f. Nervenheilk.*, Oct. 15 and Nov. 1, 1889; *Am. Jour. Insanity*, Jan., 1890.

Laufenauer on the Bromide of Rubidium in Epilepsy. — Professor Laufenauer, *Therap. Monatsh.* (abstract in *Jour. de Méd. de Paris*) has experimented with this drug in epilepsy and finds that its action is similar to that of the potassium salt, but is more decided. Its hypnotic action is also satisfactory, and, on the

whole, its properties are those of the alkaline bromide generally, but it is somewhat more efficient.—*Am. Jour. Insanity*, Jan., 1890.

Luys on Hypnotism.—This author, in a paper referred to in the *Gaz. Médicale de Paris*, No. 43, replies to certain criticisms of his former statements, and claims that he has been enabled, by means of a mechanically produced hypnotic sleep brought on by rotating mirrors, to cause favorable modifications of a number of serious nervous derangements, such as insomnia, cerebral exhaustions, persistent headaches, vertigoes, etc. In hysterical cases he was able to relieve the severe symptoms by this means, and also even to produce favorable effects in such affections as tabes and cerebral hemorrhage. In mental disorders the action was not so striking, though he claims to have relieved the morphine habit.—*Am. Jour. Insanity*. Jan., 1890.

Ziehen (T.) on the Diagnostic Value of Increased Knee-Jerk and Ankle Clonus.—The following is a series of valuable clinical rules, which are the result of the author's experience:

Unilateral exaggeration of the knee-jerk is always significant of disease.

Bilateral exaggeration of the knee-jerk is only significant when ankle clonus co-exists.

Ankle clonus may be physiological in children; in adults it is pathological.

Ankle clonus and exaggerated knee-jerk occur in sixty per cent. of cases of epilepsy, while the plantar reflex is often strikingly weak.

The combination of diminished plantar reflex with increased knee-jerks indicates functional, and not organic, disease.

Ankle clonus is found in twenty per cent. of cases of hysteria in general, but in a much higher per cent. of cases with hystero-epilepsy, paralyses, anæsthesia, etc.

Ankle clonus is rare in paralysis agitans, very marked in paramyoclonus multiplex; exists in twenty to thirty per cent. of cases of neurasthenia; in some fifty per cent. of the psychoses; in tetanus, but not in tetany.

Exaggerated knee-jerks were found in 17.2 per cent. of criminals by Marro and Tombroso.

Exaggeration of deep reflexes in spastic spinal paralysis and amyotrophic lateral sclerosis differentiates decisively progressive muscular atrophy and neuritis, where they are absent.

Ankle clonus has the same relation to degeneration of the lateral columns of the cord as Westphal's symptom has to that of the posterior columns.

In ordinary apoplexy, with the loss of consciousness a primary foot clonus is observed, which shortly disappears. But if in two weeks to two months a secondary ankle clonus appears in the paralyzed leg, it means secondary degeneration of the lateral columns, and leads to the certain anticipation of a permanent active hemicontracture.

Ankle clonus without other especial symptom leads one to suspect epilepsy of neurasthenia.

Ankle clonus with hemianæsthesia indicates hysteria; with intention-tremor, multiple sclerosis; with atrophy, amyotrophic lateral sclerosis; with spastic-paretic gait, spastic spinal paralysis or progressive paralysis; with anæsthesia of legs and paraplegia, dorsal, or cervical myelitis.

Unilateral ankle clonus in hemiplegia or monoplegia indicates a cerebral lesion, and excludes almost always a spinal affection. —*Corresp. Blätter des allg. ärzt. Vereins von Thüringen*, No. 1, 1889.

Noischewski on an Instrument by which the Blind may Perceive Light through the Skin.—This was invented and presented to the Neurological Section of the Society of Russian Physicians, in January, 1889, an instrument which he calls the electrophthalmcyclop. It consists of a small camera obscura, whose posterior wall is composed of three layers. The first is of fine metallic gauze, the second a closely approximated plate of selenium, and the last a brush-like arrangement of gold wires which are to come in contact with the skin. This veritable cyclop is applied to the middle of the forehead, and the light-rays falling into the apparatus are metamorphosed into a thermo-electric current, which is at once perceived by the glabellar nerve filaments, for the forehead has the senses of temperature and position particularly well developed.

The inventor draws the following conclusions from his experiments with the instrument:

The presence of a light-giving or of an illuminated object is manifested in the perceptive field as a sensation of warmth.

A light object on a dark background is perceived as a peripherally warm sensation, with a sensationless centre.

The degree of the sensation of warmth increases with the approach of the illuminating object, and *vice versa*. A movement of the feeling of warmth toward the right shows that the light has moved to the left, *vice versa*.

If the warm area moves downwards, the illuminating object is moving upwards, and *vice versa*.

Hence the blind will be able to see light through the mediation of tactile sensibility. It is possible for them by means of this apparatus to perceive the presence of a light object, its position and its movements from side to side, up or down or nearer and farther away.—*Centralb. f. Nervenheilk.*, March, 1889.

Müller on Warm Sand-Baths in the Neuroses.—At a meeting of the Psychiatrical Society at Berlin, Dr. Müller of Blankenburg gave his experiences of artificial warmth as a method of treatment in different neuroses. After mentioning the different forms of baths, he gave an account of a particular variety which, whilst it effectually raised the body temperature, did not submit the head and organs of respiration to a high temperature, after the manner of hot-air and vapor baths. He referred to dry, warm sand baths, by means of which most favorable results had been obtained in neurotic conditions. He has seen states of depression and insomnia considerably benefited in this way, as well as neuralgic affections, facial paralysis, and hemicrania. The abstraction of water from the body is considerable; and uric acid and urea are excreted in abundance. The condition of the heart should, so far as possible, be ascertained, prior to the use of the bath. In conclusion the author observes: "I am of opinion that the warm sand-bath merits more attention—as being the best and simplest method of warming the body throughout—than has hitherto been bestowed upon it; and that we who deal with the nervous system have especial occasion to make use of it, since, more than any other remedy, it is capable of exercising a stimulating and strengthening influence over that system."—*Zeitschr. f. Psych.*, vol. xlvi., part 3; *Am. Jour. Insanity*, April, 1890.

Blumenan (L.) on Facial Hemiatrophy.—A case is described by this author in the *Wjest. psich. i Nevropath.*, 1889, vii., 1. A factory operative, fifty years of age, presented distinct atrophy of the right lower half of the face; the cheek was here fallen in, the skin wrinkled, the lower lip thin, and the nostril narrower than on the opposite side. The atrophy also extended to the right half of the tongue, the soft palate, and the maxillary bone. His moustache only grew upon the left side; the right side of the upper lip was completely hairless. The frontal region of the face was not affected. The sensibility of the skin, electric excitability, and peripheric temperature were normal on both sides of the face.

The development of the morbid process began in his sixteenth year; the patient observed then a whitish spot upon the upper lip. In his course of five years the atrophy reached its present extent, and since then has remained without change. No circumstance could be found in his history to which one might attribute ætiological importance.—*Jour. Nerv. and Ment. Dis.*, April, 1890.

REPORT UPON DISEASES OF THE EYE AND EAR.

BY A. T. MUZZY, M.D.

Burnett (S. M.) on Blindness from Babies' Sore Eyes. — The crowning glory of medical science is not so much the cure of disease as its prevention. While this is true of adult life, and is easily appreciable, it is of still greater worth when applied to infancy. But the general public, and especially obstetricians, do not seem fully to realize this second truth. Ophthalmia neonatorum, though not a fatal disease, leaves very many of its victims helpless burdens on the community to which they were originally intended to be an active producing force. Statistics have been prepared with great pains and accuracy by individuals and communities in different parts of the world that show the percentage of those blind and those who are so from this disease. These statistics show that at least thirty per cent. of all blindness in Europe and this country is caused by ophthalmia neonatorum, that is, that there are fifteen thousand blind people out of the fifty thousand blind in this country, whose sight has been destroyed by this wholly preventable disease. Laying aside, for the moment, all considerations of

humanity and sentiment, consider, from the point of public economy, the meaning of this condition. Each one of these blind costs the government $132 a year, or in the aggregate $2,000,000. To this figure we must add the sum of what this army would have produced but for their blindness, and at $1 per head a day, the actual loss to the country each year from preventable blindness alone amounts to $7,500,000. And this disease of infancy is as surely preventable as small-pox. It is doubtful if all the epidemics of yellow fever and cholera in this country for the past one hundred years have cost the country as much as the ravages of infantile ophthalmia in ten years. The proof of our ability to prevent this disease may be found in the reports of large lying-in hospitals. Mention should first be made of the great establishment at Leipsig, Germany, under the charge of Prof. Credé, who first awakened public sentiment on this subject, proving what could be accomplished by the method now so widely and successfully used under his name. Infantile blennorrhœa occurred in this institution, before preventative measures were used, in the ratio of nine to thirteen per cent of confinements, and afterwards only a rare case in thousands, and these always traced to carelessness in treatment. Other institutions, as Berlin, Bonn, Dresden, Geissen, Marburg, and so on give no more than 0.5 per cent. of cases. Credé's method consists in an instillation of a two-per-cent. solution of nitrate of silver into the conjunctival sacs immediately after tying of the umbilical cord. Hausman's method of simply confining attention to disinfection and cleansing of the maternal mucous membrane is not sufficient. Now, though the above facts are plain and abundantly demonstrated, it is yet true that the advantages of prevention are almost wholly confined to our lying-in hospitals. But the large percentage of cases occur outside of these institutions, where no physician is employed, and among a class of people with conditions of uncleanliness most favorable for its occurrence. And these should be instructed. The health departments of the various cities could do much here by distribution of cards of instruction.—*N. Y. Med. Record*, Feb. 22, 1890.

Gradle (H.) on the Management of Blepharitis.—The treatment of blepharitis is more difficult than would at first sight appear. The usual remedy of some form of mercury in salve does not always, in fact many times does not, heal the inflamed surfaces.

The two forms—the ulcerative and non-ulcerative or squamous—require different kinds of treatment. There are three conditions known that predispose to this disease, and should be kept in mind to secure good results. Two of them are well known and acknowledged, viz., irritations and obstructions of the lachrymal canals, and errors of refraction, especially hypermetropia and astigmatism. The third should be better studied and allowed for, namely, morbid processes and condition of the nasal air passages. Any one of the varied forms of disease of the nose, including adenoid growths of the post-nasal spaces, may prove to be the predisposing but not the exciting cause of blepharitis. The ulcerative form should be treated by direct application of the nitrate-of-silver stick to the ulcerating surfaces freed from all crusts. The remaining inflammation can be controlled by oxide-of-zinc salve. The squamous sometimes yields to applications of chloral, five-per-cent. solution, when carefully applied for removal of scales. Pyrogallic-acid ointment is a quick method sometimes. But patients should be warned of its staining the skin temporarily. Another still more speedy method is with the following ointment: A three-per-cent. mixture of milk of sulphur with vaseline with the addition of three per cent. of resorcin, though this latter is not essential further than to aid in removal of scales.—*Med. News*, Feb. 8, 1890.

Hartridge (G.) on Treatment of Vitreous Opacities.—Contrary to the opinion of Mr. Ford, I believe that serum effused to take the place of lost vitreous remains transparent only a short time, vision though at first very good soon deteriorating and within twelve or eighteen months all useful vision being lost. Seven such cases I have treated with subcutaneous injections of pilocarpine. Four of these seemed to receive some benefit. No estimate of its value for these cases can be given from so few cases. Case I. was a man 44 years; R E blind from previous inflammatory trouble; L E full of vitreous opacities; this eye improved from counting figures at 3 ft. to $\frac{8}{10}$ after three weeks' treatment. Case II.; man aged 24, with numerous vitreous opacities in L E. Vision

improved from $\frac{1}{200}$ to $\frac{20}{70}$ after three weeks' treatment. Case III.; girl aged 22, with vitreous opacities in R E has advanced from $\frac{13}{200}$ to $\frac{20}{30}$ under same length of treatment. Case IV.; woman aged 54, vitreous opacities in R E; improved from $\frac{20}{200}$ to $\frac{20}{30}$ after twenty-two injections.—*Lancet*, March 22, 1890.

Green (F. W. C.) on Two New Tests for Color-Blindness.—The lantern test is one recommended for sailors and railway employés, by which dangerous persons only can be excluded. The apparatus consists of a lantern and twelve slides; six slides contain glasses colored standard red, yellow, pure green, standard green, blue and purple, and six contain modifying glasses, (ground, ribbed, and four thicknesses of a special kind of neutral glass). These neutral glasses are selected by spectroscopic examination in accordance with a theory of psycho-physical perceptions. By examining a number of educated color-blind persons, this gives a test that is sure. On knowing the class a color-blind person belongs to, it can be predicted what answers he will give. The object of the test is to show whether the candidate can detect red, green, and white light under all circumstances. The combination glasses are to prevent guessing. If the candidate calls the light shown by other than its right name, or calls it black, he should be rejected. The other test is a classification test for scientific purposes, and is not practical. It may be used as a confirmatory test. The test colors are orange, violet, red, and blue-green. These are labelled 1, 2, 3, and 4. The box contains a series of representative colors and confusion colors—150 wools, 10 skeins of silk, 10 pieces of colored cardboard, and 10 pieces of colored glass.—*Brit. Med. Jour.*, Jan. 11, 1890.

Tiffany (F. B.) on Tobacco, Its Effects upon the Eye-sight.—In the commencement of amblyopia of smokers the disturbance of vision is a functional one—that is, the retina is blunted, the real sensibility being unimpaired; and is due to some irregularity of the circulation in the centres or nerves of vision. For at first the retina and disc are apparently normal, and because that a discontinuance of the tobacco improves the sight. But after persistence in the use of tobacco the condition of the eye soon becomes organic instead of functional, until complete blindness and optic atrophy take place. The distinguishing symptom of tobacco-blindness is a scotoma centrally placed, of oval outline, with its long axis placed horizontally, including the optic disc. Over this area perception of red and green disappears more and more completely, general perception following in the wake of the color-blindness. Vision will be found to be better in subdued light, and side objects are seen better than those in the centre of the field of view. The approach of this disease is quite insidious, without pain or other symptoms; and both eyes are usually simultaneously affected. Treatment is total abstinence from tobacco, general tonics and strychnia as an antidote.—*Denver Med. Times*, Jan., 1890.

Alt (A.) on Experiences with a Case of Chronic Mixed Clonic and Tonic Blepharospasmus.—In a large majority of the cases of blepharospasmus without known cause "pressure points" may be found, pressure upon which relieving or stopping the spasm. These points are mostly where the supra- and infra-orbital nerves leave their bony canals, and the spasms are a part of general facial spasms. In treatment the general condition of the patient and possible causes are to be considered; neurasthenic and anæmic conditions; inflammations of cornea, conjunctiva. and uveal tract must be treated. When pressure points are found the constant current, and even neurectomy is indicated. The nerves at fault may be the supraorbital most frequently but sometimes the infra-orbital, the temporal branch of the malar and the inferior dental. Subcutaneous injections of morphia sometimes by frequent repetitions remove the condition. Last September a small ill-nourished man of 56 years came complaining of spasm which began 14 years previously. He had had morphine injections, and the constant current applied daily for months, had had glasses prescribed and eyelids cauterized, besides endless therapeutic and tonic treatment. The eyelids were seen to be tightly closed save that at intervals of a few minutes clonic spasms replaced the tonic, and a mere glimpse was secured of his surroundings. Pressure over the supraorbital notch lessened the spasm for a short time, while pressure over both supra- and infra-orbital notches and foramina of both sides of the face produced a marked effect. Instillation of a few drops of a 4 % solution

of cocaine also relieved the condition. The cocaine failed to have any effect within 24 hours. Next the orbicularis muscle was stretched by spring-lid speculum. This relieved about as long as the cocaine. Next myotomy at the external canthus of each eye was performed. This satisfied the patient about two weeks, enabling the patient to do a little work at his trade. Finally neurectomy of the left supraorbital nerve was made, about an inch of the nerve being removed. This produced marked relief in the spasms of the upper lid. And after a similar operation on the corresponding infraorbital nerve the patient departed fully satisfied. But in place of the blepharospasm the general facial spasm seemed in no way better, if not somewhat worse. But no further operation was allowed.—*Am. Jour. Ophthal.*, Nov., 1889.

Bronner (A.). Some Relations between the Diseases of the Nose and Eye.—The anatomical relation between these two regions and organs is an intimate and direct one. The nasal duct connects the mucous surfaces, the venous supply is directly united by the frontal veins, lachrymal plexus, ethmoidal veins, and so on; and an intimate reflex vaso-motor union exists. A large number of cases of epiphora depend for their existence on inflamed swollen mucous membrane of the nose. Nearly all persons who suffer from chronic hypertrophic rhinitis suffer also from epiphora. Still more frequently is the coexistence of mucocele and lachrymal-sac abscess with inflammations, especially caries of the turbinated bones. In all cases of unilateral conjunctivitis, the lachrymal sac and nares should be carefully inspected. Another very frequent affection of cornea and conjunctiva in children, the marginal or phlyctenular keratitis, which recurs so often, nearly always is accompanied by nasal trouble. And if we carefully treat and cure the rhinitis, the ophthalmia probably will not return. Another class of affections of the eye has also relation many times to morbid conditions of the nose, viz., muscular asthenopia with normal vision and accommodation. Rhinitis and inflammation of the maxillary sinus many times cause orbital neuralgias. Besides these, rare instances are recorded of dimness of vision, glaucoma, scintillating scotoma, etc., from chronic hypertrophic rhinitis, and empyema of maxillary sinus. —*Am. Jour. Ophthal.*, Nov., 1889.

Love (J. K.) An Inquiry into the Limits of Hearing.—Untutored ears are as good for detecting tones of 256 and 2048 vibrations as of 512 and 1024 vibrations —that is, at the usual limits of hearing as through middle of the scale. And within this range a variation of a $\frac{1}{60}$ semitone can be distinguished with certainty by good ears. The usual methods of measuring hearing in the consulting-room, the watch, the tuning-fork, and whispered speech are all defective in accuracy. Watches differ in stroke; tuning-forks are also rough, giving different intensities of sound according to the force of the stroke which starts their vibrations. Speech can only approach accuracy when whispered. Of acoumeters, Politzer's is fairly accurate, consisting of a small steel cylinder, on which a steel hammer falls from a given distance. This is convenient, but rather too loud for offices of usual size, being normally heard 15 metres, or 50 feet. Hartmann has endeavored to make use of the telephone, but the mechanism is too complicated and the range of tones too small.

Experience shows wide variations in appreciation of differences of pitch. Keenness of perception is found where there has been vocal and instrumental training, but especially the latter. And often this keenness is met with where there has been no training, showing a naturally fine ear. But the opposite condition of obtuseness is also met, and that in spite of training. One music-teacher speaks of a pupil who, after three months' training, could tell no difference between adjoining notes, or even from *C* to *F* or *A*. But he began to distinguish some difference between *C* and C^1. Discords had no unpleasantness for him. His hearing was good otherwise. He recognized some tunes, but apparently by volume of sound and time only. The musical bias of his family was unpronounced; one of his sisters had her meatus congenitally closed by a membrane. Still he appreciated the beauty of a single note as of a finger on a finger-glass; he was fond of church bells and chimes. And he had a delicate ear for the metre of poetry. From careful search it is evident that cases as extreme as the above are rare, and that many who could not at first distinguish neighboring notes rapidly improve under training. In conclusion (1), notes produced by 15 or 16 vibrations a second are the

lowest which can be perceived by the human ear, many cannot perceive notes caused by less than 24 vibrations. (2) The very high notes are produced by very small tuning-forks, or Galton's whistle with vibrations of forty thousand distinguished by Dr. Preyre and a few other observers. Observations show that most can hear nothing over twenty or thirty thousand vibrations per second. Some are deaf to all over five thousand two hundred. (3) For untrained or very slightly trained ears the slightest difference perceptible may freely be put down at from $\frac{1}{8}$ to $\frac{1}{10}$ semitone, though this is difficult to state exactly. All observers, but especially the untrained, detect sharpened intervals better than the flattened.—*Glas. Med. Jour.*, Sept., 1888.

MISCELLANY.

Broome (G. W.) on Curtailment of the Scrotum for Sexual Disorders.—The author thinks that many forms of impotence, including spermatorrhœa, depend on a long and flaccid scrotum and other coexisting and consequent pathological conditions.

He cites an illustrative case as follows :

A man of twenty-eight had been reduced to a complete state of sexual hypochondriasis by this condition. His scrotum was long, flabby, and thin. He had masturbated most of his life. His only attempts to copulate were failures ; neither was he able at the opportune moment to maintain an erection or effect intromission, yet there was a constant ejaculation of semen. He stated that for several years he suffered from an almost intolerable dragging weight in his testicles and along the cord, and a constant pain in his back. There was varicocele on the left side. He was sent to the hospital, where about three inches of his scrotum were removed, and soon after the operation he commenced to improve. The dragging weight was scarcely felt after he got up, and the mental hypochondriasis was no longer a burden to him.

The operation is performed as follows :

The anus, perineum, scrotum, penis, and inner aspect of the thigh must be energetically scrubbed in hot water with soap and a clean brush ; then the operator's hands should be scrubbed, likewise his knife and the clamp. Then place a bandage around the patient's abdomen, another around his penis, and fix the ends of the latter to the former, in order to carry and hold the penis against the abdomen. This being properly done, apply the clamp, carefully engaging it immediately above the line at which it is proposed to amputate the scrotum. This point of selection should be high enough to form, when healed, a firm floor for the support of the testicles. A number of interrupted sutures are then secured, between the divided lips of the integument only, by means of a small straight needle armed with fine sterilized silk. The integument must be evenly united over the dartos in this way, in order that healing by first intention may be secured. This being completed, the dartos and integument are firmly stitched together with a small Hagedorn needle, and the catgut suture passed through each one of the eyelets in the instrument. The instrument must be left firmly adjusted until the two membranes are safely and completely united, for by disengaging the dartos from the jaws of the clamp before it has been firmly fixed to the skin, alarming and uncontrollable hemorrhage may result. In fact the clamp should be left *in situ* for several hours until exsiccation is well under way. The wound itself is dressed with cyanide of zinc and mercury rubbed in ordinary gauze ; the penis is kept bandaged until the wound is healed.—*Weekly Med. Rev.*, March 11, 1890.

Brewer (G. E.) on Accidents, Complications, and Results Following Internal Urethrotomy.—From a study of one hundred and twenty cases of stricture of the urethra, the author concludes :

1st. That internal urethrotomy, as a means of treating stricture of the anterior urethra, is a comparatively safe operation, no deaths occurring in my series of cases, and but one case of severe illness, and that directly traceable to my own bad judgment regarding the method of operating.

2d. That, by the intelligent application of a few well-known measures, alarming hemorrhage can, in nearly all cases, be avoided.

3d. That the occurrence of a more or less lasting curvature of the penis after operation, is probably due to the extension of the incision beyond the necessary limits, and that a tendency towards this is aggravated by the prevention, by any means, of

complete erection of the organ subsequent to the operation.

4th. That, with the exception of the meatus, the practice of dividing anterior strictures on the floor of the urethra should be condemned as dangerous procedure.

5th. That the passage of instruments through the deep urethra should, if possible, be avoided immediately after the operation.

6th. That, in a majority of cases, by a thorough and complete division of all stricture bands, a radical cure, and complete restoration of the canal to its normal calibre, may be expected.

7th. That all attempts to prevent recontraction in imperfectly divided strictures by means of dilatation, are useless.—*Internat. Jour. of Surg.*, Jan., 1890.

Gardner (Wm.) on Abdominal Section in Tubercle of the Peritoneum and Uterine Appendages.—The hitherto accepted universally fatal prognosis of tubercular peritonitis must, as a result of what we have learnt by abdominal section, be revised. It is certain that recovery has taken place in many cases after abdominal section, and probably in others not so treated.

There is some evidence in favor of the theory that a cheesy deposit, the result of suppuration, is the parent of tubercle, wherever found.

The early removal of such focus is urgent in certain subjects strongly predisposed to tubercle, when other indications may not be strong enough to justify it.

Abdominal section in these, as in less serious conditions, has, with proper precautions, been, as an operation, recovered from in such a large proportion of cases as to amply justify its performance to clear up a doubtful case.

A mass of evidence has accumulated in favor of the beneficial effects of abdominal section in tubercular peritonitis such as it is difficult to resist.—*Montreal Med. Jour*, March, 1890

Grigg (W. C.) on Heredity as to Triplets.—I was consulted by a Mrs. M. B., a Wiltshire woman, aged forty-four, who gave me this history of her family: Great-grandmother, maternal side, had nine children at three births, triplets each time. Grandmother had seven children, triplets once, twins twice. Her mother had twelve children, once triplets, twice twins, five single births. Her mother's sister had seven children, triplets once, four single births. Her mother and her aunt married two brothers. Her mother had two brothers who married; neither had children. Mrs. M. B has had sixteen children, triplets twice, ten single births. She has seven girls living. Eldest daughter, aged twenty-five, married, has four children, one triplet and one single birth. Second daughter married September, 1889; pregnant. She states she herself was one of a twin, and her mother also. Her family seems to be well-known in the village whence she comes as the "triplet and twin family." Her maternal great aunt, aged ninety, single, is still living, who declares that her grandmother told her that her grandmother informed her triplets were in the family as far back as any record could be obtained.—*Brit. Med. Jour.*, March 8, 1890.

Somers (L. N. U.) on Epilepsy Caused by Imperforate Hymen.—Lizzie K——, born June 4, 1869, was brought to me by her mother to be treated for falling sickness, from which she had suffered off and on for about three years. She belongs to a strong, healthy family. Her mother is fifty-four years of age, has enjoyed exceptionally good health, and does not remember any of her relations suffering from fits or any cerebral infirmity. She is no relation to her husband, who was strong and active up to the time of his death, which was caused by a fall from a horse in his sixty-third year. He was a man of temperate habits, the third child of a family of ten, eight of whom are still living; no relative of his was known to have epilepsy or imbecility. The patient was born at the full time, after an easy and natural labor; she is the fifth of eight children, all of whom are in excellent health. She was four years old when she had whooping-cough, and was six years old when she had measles. She has never had scarlet fever, small-pox, or any other disorder, and does not remember having received any fall or blow on her head. She began to complain about four years ago, when she became subject to what she considered repeated dyspeptic attacks, at which times she suffered from backache, sickness, constipation, flushings, loss of appetite, abdominal pains, swelling and general discomfort, frequently from headache, and after a while from frequent desire to micturate. This condition of things having lasted for sev-

eral months, the family doctor was at last consulted. She brought the prescription he gave her at that time. He prescribed: Pil. aloes et ferri. ℞ Decoc. aloes co., mist. ferri aromat., spt. am. ar., aq camph. ad ℥ viij.; ℥ j. c i. pil. ter die; and ordered her to put her feet in mustard and warm water at bedtime, and place a large linseed and mustard poultice over both breasts at least one night in the week, at the same time to have a liberal diet, with plenty of milk. This course of treatment, instead of relieving, seemed to aggravate the symptoms, which now assumed an intermittent character. She was completely prostrated for four or five days at a time, then she appeared to improve, and was, comparatively speaking, pretty comfortable for about three weeks, when the symptoms invariably returned in an aggravated form. On the night of May 10, 1886, she retired at an early hour, as she did not feel quite well. She had been in bed about three hours when her mother was startled by hearing her scream; she immediately hastened to her assistance, and found her working in a fit; her eyes were fixed and staring, and she frothed considerably at the mouth. A messenger was at once sent for the nearest medical man, but before he arrived she had regained consciousness and felt quite herself again, with the exception of a slight headache. The next day and the day following she was seized with similar attacks, and was then free from them for about five months; after that time the fits became more and more frequent, and during the last twelve months she has been attacked for a few days at the beginning and end of each month. Last month she has had as many as five fits in two days. This history was given partly by the mother and partly by the patient herself, who appeared to be an intelligent, well-educated girl, about medium height, of slight build, and dark complexion. In answer to my questions, she stated her appetite was bad, her bowels costive, urine clear and healthy-looking, but passed frequently in small quantities. She suffered frequently from headache, fulness after meals, flatulence, heart-beat, and a short dry cough, which was very troublesome at times. She had never menstruated, but thought it must have something to do with her present illness, as she suffered more at the beginning and end of each month than between times. I suggested that it would be necessary to make an examination of the generative organs, but she would not hear of such a thing. However, when she undid her jacket in order that I might examine her chest, I was struck by the abnormal size of her abdomen, and putting this and her dislike to a vaginal examination together, I must say I strongly suspected that I was being imposed upon, and that what really was the matter she endeavored to conceal; in fact, I considered she was *enceinte*. I did not express my opinion, but prescribed an alkaline mixture with bromide of potassium, and asked her to call again in a few days. She did not return; but in about two or three weeks afterwards I was asked to come at once to Mrs. K——'s, as her daughter was in a fit. I went without delay, but found she had just recovered. I ordered her to bed, and spoke seriously to the mother as to the necessity of making a thorough examination. She quite agreed with me, but was compelled to use an amount of persuasion before her daughter consented, which she finally did. I accordingly examined her in the dorsal position, and on inspection found the abdomen symmetrically enlarged and very prominent. On palpation, I could detect a central firm tumor well defined, which was evidently the uterus enlarged. On proceeding to make a vaginal examination, I found the orifice obstructed by a distinct fluctuating swelling, which felt uncommonly like the unruptured membranes in labor, and which I had little doubt was an imperforate hymen distended by some fluid in the vagina. Having made a sufficient diagnosis, I had scarcely concluded my examination when the patient was seized with an epileptic fit, which lasted for over a minute; her features became distorted, the eyeballs turned up, the eyelids wide open, and the pupils dilated; the thumbs were shut close in the palms of the hands, and the limbs agitated by convulsive motions. This was succeeded by a kind of stupor and general feeling of lassitude.

Having weighed the advantages and disadvantages of the several methods recommended for the evacuation of the fluid, I decided upon dividing the hymen by a free incision, and rapidly evacuating the fluid. When I explained the nature of the case to the girl and her mother, they not only consented to allow me to operate, but in fact urged me to do so,

Mrs. K—— adding that on account of the uncharitable remarks of some of her daughter's companions she was willing to incur any risk in order that she might get well. Next morning, having placed the patient in the lithotomy position, and cleansed the parts well with a strong solution of Condy's fluid in warm water, I divided the imperforate hymen by a free incision, which immediately gave exit to a thick sanious discharge, and allowed me to wash out the uterus and vagina with a solution of permanganate of potash, after which I placed a firm pad over the hypogastrium and retained it in position with an obstetric binder. A plug of absorbent cotton saturated in a weak solution of carbolic acid in glycerine was placed in the vagina, and an opiate administered. The patient was kept in bed and ordered a low but nourishing diet. The uterus and vagina were well cleansed with Condy's fluid in an injection which was used twice a day, the plug of absorbent cotton being changed each time. She made a wonderfully quick recovery, without a single unfavorable symptom, and at the end of ten days was allowed to get up. Though fourteen months have elapsed since the operation she has had none of her old troubles, and is perfectly free from any thing like fits. Seven weeks after the operation she menstruated for two days, but since that time the catamenia have been quite regular. She has gained weight, strength, color, and spirits to a wonderful degree, and may now, I think, be considered well.—*Lancet*, May 10, 1890.

White (J. W.) on the Modern Treatment of Vesical Calculus in Male Children. — The author believes the following conclusions to be justifiable :

1. In every case of calculus in male children litholapxy, on account of ease of performance, low mortality, speedy recovery, and absence of danger of emasculation, should be the operation of predilection, division of the meatus being freely resorted to if that portion of the urethra offers an obstacle to the introduction of instruments.

2. The lithotrite and evacuating-tube should be of a size which can be inserted into the bladder without much effort or over-distention, and great gentleness should be observed in passing these instruments.

3. They should be withdrawn and reintroduced as seldom as possible, the stone being finely pulverized before the lithotrite is taken out at all. In seeking for or attempting to seize the stone, care should be taken to avoid such wide separation of the blades as will bring the male blade in frequent contact with the vesical neck. The crushing should invariably be done only after rotating the blades into the centre of the bladder. Every particle of the calculus dust should be evacuated.

4. Rest in bed, milk diet, and the sterilization of the urine by boric acid or salol given internally both before and after the operation are valuable adjuvants. During the operation every antiseptic precaution should be observed.

5. The exceptional cases of calculi which are both large and hard may be best treated by suprapubic lithotomy, but neither unusual size nor a moderate degree of density should of itself alone be thought positively to contra-indicate litholapaxy.

6. Perineal lithotomy has now a very limited field, and should be employed chiefly in those cases of stones thought to be of small or medium size in which no lithotrite, however small, can be introduced with safety.—*Med. News*, May 17, 1890.

Barling (G.) on Carcinoma of the Bladder.—The hope of cure by excision, of malignant growths in the bladder lies in early diagnosis, before the growth has attained considerable size, before the patients' powers have been sapped by repeated hemorrhage, and before secondary obstructive changes have taken place in the kidneys, and before secondary growths have occurred.

For those rare cases in which the vertex and its neighborhood is the seat of growth, Antal's extra-peritoneal method should be followed, if possible. By it about half the bladder may be removed, but the greater the amount resected, the greater the difficulty in stripping the peritoneum and in subsequently closing the opening. The peritoneum is of considerable thickness here, and is apt to strip up some of the external muscular coat with it, especially if chronic cystitis has existed. The peritoneum is much more easily peeled off when the bladder is full than when it is empty. The edges of the wound in the bladder should be closed as completely as possible by suture, especially at the angles, and the reflected peritoneum must be carefully fixed in apposition to the remnants of the bladder walls. When the resection has been so extensive that the bladder cannot

be closed, its edges should be stitched to the skin wound, and the bladder cavity closed, later, by plastic operation.

When the intra-peritoneal plan had been followed, the peritoneal wound must be carefully closed with Lembert's suture, and the remaining part by ordinary interrupted suture. If this be not possible, the part of the wound outside the peritoneum should be stitched to the abdominal wall.

Silk is the best material for suture, and it should carefully exclude the mucous membrane.—*Birmingham Med. Rev.*, Mar., 1890.

The Antiseptic Tin Dressing for Chronic Ulcers of the Leg.—The last report of the Boston City Hospital contains an account of the tin dressing for ulcers of the leg, used by Dr. Francis S. Watson, at that institution. The ulcer and surrounding surface are soaked in a solution of corrosive sublimate, 1 part to 4,000, for ten to fifteen minutes. The surface about the ulcer is then dried and thoroughly cleansed, the ulcer itself being lightly dusted with calomel or iodoform. A piece of protective of Mackintosh cloth is then cut out, of the shape of the ulcer, and in size a little larger, covering a little more than the surface of the ulcer. Next a piece of sheet-tin is cut to the shape and size of the ulcer, and bent to fit smoothly the curve and contour of the leg at this point. This is laid over the protective after that has been laid on the ulcer with as smooth a surface as possible, in order that, when the time comes to change the dressing, it can be lifted off without tearing up the newly formed tissues beneath it. Over the tin is placed a square of sterilized or sublimated gauze, dry, and outside of this a larger square of antiseptic gauze of some kind, enveloping the leg; then the whole is held in place by a bandage extending from the toes to the knee.—*Jour. Am. Med. Assn.*, May 17, 1890.

Suicide by Means of a Pin.—At the Société de Biologie, Dr. Magnan related a case of suicide by means of a pin. It was that of a melancholic patient, a young woman, in his ward at the Sainte Anne Asylum, who manifested a suicidal tendency at different times, and ultimately succeeded in compassing her death by plunging a pin into the chest under the left breast. This pin, which was of the ordinary size (three centimetres) pierced the sixth intercostal space, traversed the pericardium, and lacerated in different points the surface of the myocardium. Death took place from syncope. The arrest of the heart was due to escape of the blood, which filled three fourths of the inferior portion of the pericardium, although no important vessel was wounded. Dr. Brown Séquard observed that this fact proved that acupuncture of the heart, which was formerly practised, may be followed by fatal accidents. Dr. Polaillon remarked that death in such cases did not always, as in the case related by Dr. Magnan, result from compression of the heart by intra-pericardiac hemorrhage, but by reflex action, by syncope. This is particularly the case when wounds of the heart are superficial, not penetrating into the intra-pericardiac cavities. It happens, however, that larger bodies—bullets, for instance,—have lodged in the thickness of the myocardium without giving rise to accidents of this nature.—*Lancet*, May 10, 1890.

Martin (E.) and Hiller (H. M.) on the Effect of Mercury upon the Blood of Syphilitics.—We believe that neither the blood condition in syphilis nor the action of mercury upon the blood has yet been formulated. Each observer has seen too few cases for comprehensive conclusion. The previous condition of the patient before contracting syphilis has a modifying influence upon the blood which has not been duly considered. In opposition to Lezius, we believe that in the majority of cases the diminution in hæmoglobin is less than the corpuscular count would suggest. Our observations have certainly accorded more with those of De Luca in this respect. We think it must also be granted that both corpuscles and hæmoglobin are reduced in quantity by syphilis, and that mercury prevents the reduction. That the mercury acts as a tonic remains to be proven, since increase in the number of blood-cells and in the body-weight may be the result of retarded oxidation as well as of tonic action.

We believe that the "tonic" dose for each individual must be determined by his susceptibility to the drug. Thus we have given for weeks at a time three grains of protiodide daily with beneficial effects, and again we have produced marked constitutional effects by half a grain of the same drug given three days in succession. An examination of the blood will afford

a valuable guide as to the amount of mercury to be given, since an overdose produces a very rapid diminution in the corpuscular count and the amount of hæmoglobin. It must be borne in mind, however, that in the beginning of mercurial treatment there is often a falling-off of the blood condition, due to the disease itself, and apparently taking place before the mercury has begun to produce any effect.—*Med. News*, May 17, 1890.

Lane (J. E.) on Urethral Chancres.—The object of this paper was to define the exact locality in the urethra where the syphilitic chancre might be met with, to draw attention to certain peculiarities in the progress of such sores, and to note the points by which they might be distinguished from other affections resembling them. In 373 cases where the position of the initial lesion had been accurately observed, Mr. Lane had met with eight sores confined to the urethra, and ten involving the meatus and commencement of the urethral channel. All the sores situated behind the meatus were in the fossa navicularis, and it was contended that sores were never met with beyond the anterior fourth of the urethra. The diagnosis of these cases was often a matter of considerable difficulty, the diseases with which they might be confounded being chancroids and gonorrhœa. Chancroids were seldom if ever confined to the urethra; the diagnosis might be arrived at by inoculations of the patient, and by the fact that while chancroid is essentially a destructive process, the chancre is a small-celled infiltration, and in this situation is seldom attended with any loss of tissue. From gonorrhœa a urethral chancre might be distinguished by the induration of the inguinal glands and of the dorsal lymphatic of the penis, by the nature of the urethral discharge, and by the acute and localized pain during micturition. A complication occasionally met with in these cases was retention of urine caused by acute congestion of the urethra and predisposed to by narrowness of the meatus, while at a later date a stricture might result from contraction of the cicatrix.

Mr. Lane stated that he had never met with a case of chancre in the female urethra, nor did he know of any recorded instance. He believed that gonorrhœa and syphilis frequently co-existed, though the thick discharge of gonorrhœa was sometimes mistaken for the thinner discharge which accompanied a urethral chancre. He thought that urethral chancres were more common in persons who had a narrow meatus. Mr. Lane considered that tannate of mercury in doses of one to two grains with a little opium gave the best results in the treatment of primary syphilis, as the patient was thereby rapidly brought under the influence of the drug whilst his digestive system was not upset. The roseolous eruption of syphilis was sometimes confounded with a copaiba rash, and in such cases again the diagnosis might occasionally be assisted by examining the urethra.—*Med. Press*, May 7, 1890.

Foxwell on Syphilis of the Lung.—A left lung, the upper lobe of which had undergone a uniform fibrosis was exhibited. The vessels and bronchi were much thickened. At the apex were several irregular, pus-containing cavities of quite recent formation. The pleura was much affected, perhaps primarily so, in places being a third of an inch thick and almost cartilaginous in texture. Its two layers were adherent except when separated by pus. The lower lobe was collapsed but otherwise normal. The patient from whom the specimen was taken was admitted with a tumor the size of a large orange centring over the second left space. This was incised and the apex of lung drained through it; but fresh openings arose lower down, with much erosion of the corresponding ribs. The right chest was unaffected. The patient died of exhaustion. The man only gave a nine months' history of cough and expectoration, but had been getting weak for six months prior to this. No bacilli were found, but only one examination was made. Though no history of syphilis was obtained and though syphilis very rarely produces a diffused mischief such as this was, yet Dr. Foxwell believed syphilis was most probably the cause of the condition.—*Birmingham Med. Rev.*, May, 1890.

The Functions of the Cerebellum.—The views so ably propounded by Dr. Gowers in our last issue upon the *modus operandi* of the co-ordinating functions of the cerebellum—a function known to physiology since the days of Flourens—deserves the attention of physiologists. The co-ordination of movements demands, as Dr. Gowers points out, "the co-ordination

of the activity of the cells" of the cerebral cortex. The connection subsisting between the cerebellum and the cerebrum suggests a path whereby the former can operate on the latter, and necessitates the assumption of an upward impulse from the cerebellum to the cortex cerebri. That the cerebellum itself receives upward impulses from the muscles through the spinal cord is supported by strong evidence, anatomical and pathological; whilst there is no similar ground for believing that the cerebellum exerts its influence in a downward direction, as would be the case were it alone to be regarded as the co-ordinating centre. The well-reasoned arguments of Dr. Gowers requires no further exposition than he has given to them. They seem to be irresistible, and they harmonize the facts bearing on the maintenance of equilibrium and the co-ordination of voluntary muscular effort in a satisfactory and sufficient manner.—*Lancet*, May 10, 1870.

Hereditary Infantile Spastic Paraplegia.—In two former volumes of the *St. Bartholomew's Hospital Reports*, Dr. Gee has recorded cases of spastic paraplegia, apparently of congenital origin. In the volume recently issued, he has published an instance where the disease seemed to be inherited. A brother and sister, aged 11 and 12 respectively, were evidently the subjects of the disease. There was the usual history of their never having been able to walk properly, and in the case of the girl, before she began to walk, the legs were crossed; in both the legs were slightly bent at the knees, and the thighs were adducted; the knee-jerks were active, but there was no ankle-clonus. In both there was some tendency for the hands to be affected, as shown by a cramped position of the hand and adduction of the thumbs, more marked in the boy than the girl; the muscles acted well to faradism. Their father, aged 37, had never been able to walk properly; he was unable to walk without crutches, and his legs were crossed in walking; his thighs were adducted, and the thigh muscles well developed; the knee-jerks were very active. The muscles of his arms were well developed, the deltoids especially so, but there was marked wasting of the muscles of the thenar and hypothenar eminences and of the interossei in both hands. All the muscles acted well to faradism, but the wasted muscles would not respond to the strongest galvanic current. There was no history of syphilis. As a further evidence of inherited nervous taint, it may be mentioned that a sister of his mother was said to have been completely paralyzed during her whole life, and that two of his cousins on the mother's side were deaf-mutes, and one was born without any fingers.—*Brit. Med. Jour.*, April 26, 1890.

Pratt (R.) and Bond (C. J.) on Dilated Urachus Treated by Incision and Drainage.—A gentleman aged fifty-four years consulted Dr. Pratt on June 8, 1889, complaining of pain and distension in the bowels and increasing general weakness. He was quite well until the previous November, when he was taken ill with pains in the lower part of the bowels; he kept in bed for three weeks, and in the house for four months. He could not account for the onset of the disease in any way; there had been no blow, lifting of heavy weights, or straining of any kind. His occupation was that of a storekeeper and clerk near New York, where he had lived many years. He had gonorrhœa when twenty-one years of age, but never had any symptom of syphilis. He led a very intemperate life until seven or eight years ago; since then he has been a moderate drinker. A grandmother and an aunt were supposed to have died from cancer of the bowels; the patient's father, a grandfather, three brothers, and one sister had died from consumption. The abdomen was found to be much distended in the lower half in front; the distended area was dull on percussion, and extended as high as three fingers' breadth above the umbilicus and down as far as the pubes, laterally on each side as far as vertical lines drawn through the anterior superior iliac spines, projecting rather more to the left than to the right side; the flanks were perfectly resonant, the tumor fluctuated. The circumference of the abdomen between the umbilicus and pubes measured 41½ in.; nine months ago it was 34 in. He weighed 182 lbs.; his weight for the last twenty years having been 175 lbs. Height, 6 ft. 1 in. The lungs appeared to be normal. The cardiac apex beat was in the left nipple line; the first sound at apex was weak; no murmur. Pulse 84, regular, small, and compressible. Liver dulness extended two fingers' breadth below the margin of the thorax, the upper limit was normal. No trouble with mictu-

rition or defecation, except slight constipation. Urine acid, no deposit, pale sherry color, sp. gr. 1020, no albumen, no sugar, urea 1.45 per cent., quantity about normal. A catheter was passed immediately after micturition, only a few drops of urine being withdrawn. Examined per rectum the prostate was not enlarged, but there was a fulness filling up the left side of the pelvis. On June 15, 1889, the tumor was aspirated, and about one drachm of a gummy, semi-transparent fluid withdrawn which blocked the tube; this contained only a trace of albumen, but a large quantity of mucin, as shown by the percipitate it gave with acetic acid, which was soluble in nitric acid; examined microscopically, it showed many leucocytes. The temperature was ordered to be taken. On June 30, the temperature was about 99° in the morning, at or above 100° in the evening. There had also been profuse night sweats.

On July 9, 1889, Mr. Bond made a four-inch median incision midway between the umbilicus and the pubes. After dividing the linea alba a very thick membrane was reached resembling the peritoneum much thickened by tubercular peritonitis. This proved to be the outer wall of the cyst; it was divided, and a very large quantity, of which over a gallon was measured, of a ropy, gummy, semi-solid, laminated substance, having the appearance and consistence of semi-discolorized fibrin, was partly squeezed and partly drawn out in stringy layers. A considerable quantity was left in the cavity, as any attempt to sponge it off the inner surface of the cyst wall left a red raw surface which bled freely, the blood being remarkably fluid. On exploring the cavity with the hand and arm, it was found to extend upward to beneath the liver, and downward into the pelvis; the intestines could be made out behind and at the sides of the cyst, though shut off and separated from it. The cavity of the peritoneum was not opened. Keith's glass drainage-tube was placed in the wound, reaching to the floor of the pelvis, and the rest of the incision closed. Strict antiseptics were used and a sublimate wool dressing applied over the tube and the wound. The fluid contained not more than traces of albumen, the whole being practically mucus and fibrin, with a large predominance of the former; microscopic examination showed abundance of mucus-corpuscles, with which were mixed some blood-corpuscles. The after-progress of the case was very satisfactory; the wound remained aseptic, and large quantities of the mucoid material were aspirated or squeezed out through the tube, which was removed, cleaned, and replaced twice a day. The cyst walls shrank very considerably, the evening temperature did not reach the normal until six weeks after the operation, and the night-sweats continued for several weeks also. In December, 1889, on his departure for America, he seemed to be in good health, could walk nine miles at a stretch, and his appetite was excellent; there still remained an irregular-shaped cavity with thickened walls, capable of holding half a pint of fluid. Mucoid material was secreted daily; the discharge of this, however, which was quite sweet, did not seem in any way to depress the health. In a letter dated February 27, 1890, the patient says the wound is still kept open by a glass tube, it discharges clear watery fluid with very little of the jelly-like material, the discharge is not at all offensive, and the general health is excellent. He works thirteen hours a day; his weight is one hundred and seventy-five pounds, and he measures thirty-six inches round the abdomen, between the umbilicus and pubes. He has strict orders not to allow the wound to close. The diagnosis rested between hydatid tumor which had undergone mucoid degeneration, and an enormously dilated urachus. The detection of mucus in the contents of the cyst excluded hydatid tumor as well as encysted peritonitis, for, as Mr. Shattock, who kindly examined some of the fluid, writes, it is impossible for a mucous fluid to be secreted by a serous membrane. The presence of myxomatous tumor was negatived at the operation. The case must therefore be one of immensely dilated persistent urachus.—*Lancet*, April 26, 1890.

Carothers (W. H.) on a Very Short Umbilical Cord.—On February 24th I was called to attend Mrs. P. in her second labor. Pains began during the evening but were light and irregular all night. I left her and returned in a few hours finding the os two inches in diameter, pains about ten or twelve minutes apart. Again left for an hour, making some calls in the immediate neighborhood. On my return found expulsive pains had begun. In a short time the head was born but there it

stopped. Suspecting the cord to be around the child's neck, I felt for it, but could find nothing. With little effort I brought down both arms, but with the head and shoulders born the child would come no further. I passed my finger up to the attachment of the cord, and found it drawn tight, so as to hold the child in that position. I slipped my other hand, or rather two fingers up and pulled the cord in two, when the body slipped into the world at once, I holding the end of the cord attached to the child in one hand, the placental end in the other. I then gave the child to the nurse, instructing her to hold its end of the cord, while I tied my end, which I had to do almost within the vaginal canal. The placenta came away in fifteen or twenty minutes, when I found the placental end of the cord only about 3½ or 4 inches in length, the end attached to the child about an inch long.

I have seen cords so long that they were wound twice around the child's neck and still allowed it to be born, but I never saw another one of the very short kind.—*N. W. Lancet*, Feb. 15, 1890.

Swaney (A. J.) on Incontinence of Urine in Children.—The various causes of this affection he tabulated as follows: 1. Excessive acidity of the urine, which is usually caused by excessive formation of uric acid. 2. Over-irritability of the muscular coat of the bladder, even when the urine is neutral. 3. Weakness of the sphincter. In such a case the urine is not passed as rapidly, or in a full stream, as when the cause is a forcibly acting detrusor. 4. From reflex action. Any source of irritation in or about the genital tract may be a cause of incontinence of urine. Local examination may discover a balanitis or adhesions between the prepuce and glans penis, with smegma around the corona. Two such cases had come under his observation in the last year. 5. Too great a quantity of urine, from the child drinking too large a quantity of fluids. 6. Vesical calculi. 7. Malformation of the bladder. Several cases have been reported where persistent and irremediable incontinence was induced by one or both ureters opening into the urethra. 8. Contraction of the walls of the bladder, owing to hypertrophy of the muscular layer reducing the capacity of the bladder to one or two ounces. This he found to be the condition of the bladder in a case which he would report. The walls of the bladder were contracted so much that the patient's bladder would not hold more than one and a half ounces of water.

The treatment of incontinence of urine must depend upon the discovery of the proper cause in each specific case. Where the urine is highly acid it should be neutralized by the administration of alkalies. The acetate of potash is one of the best preparation for this purpose. Fruits often do well in children old enough to partake of them, as the vegetable acids are changed to alkaline bases in the system. Where the fault is from the detrusor acting too vigorously, belladonna serves as a specific. Five drops of the tincture of belladonna may be given three times a day at first, and the dose increased by single drops, until there is some dryness of the throat and flushing of the skin. If the drug is to control the incontinence at all, it will do so when such effects are produced For a lack of force in the sphincter ergot in full doses is indicated. A good effect follows the injection of five or six drops of the fluid extract of ergot into the connective tissue of the ischio-rectal fossa, as recommended by Dr. H. D. Chapin, of New York. In all cases of incontinence of urine every thing possible should be done to tone up the nervous system, and to this end the speaker mentioned syrup of the iodide of iron and strychnine in full doses as being very valuable.—*Med. Record*, May 3, 1890.

Hubbard (C. G.) on the Birth of a Very Small Living Child.—On January 18, 1890, I was called to see Mrs. B., aged about thirty-five, the mother of seven children. I found her in pains. She thought she was about seven months advanced in pregnancy. The day previous her waters had broken and had been discharging ever since. I found the mouth of the uterus closed, and gave an opiate and left her. On February 2d I was called at 2 A.M. and found her in labor. The os was dilated to the size of a silver half-dollar. The pains were frequent and very severe. The uterine walls were unusually thick. The head presented at the os and was apparently of the size of that of a six-months fœtus, but the pains accomplished but little until 4 : 30 A.M., when I ruptured the membranes, and the child was born at 6 : 15 A.M. alive. The child was too small to dress, so I wrapped it in soft flannels and

surrounded it with bottles of hot water. The child grew stronger and cried quite loudly. It measured ten inches in length, its head three inches in length and eight inches in circumference around its ears. Its thighs were two inches and a half in circumference. Its fingers were but a trifle larger than a knitting-needle. It weighed a pound and two ounces, and was well formed. Its finger-nails were perfect. It lived eight hours, dying at 2 P.M. the same day. It was emaciated, with a shrivelled skin. The mother was a strong, healthy woman, with no history of any constitutional disease. The father is intemperate. It was the smallest living child I ever saw. —*N. Y. Med. Jour.*, May 3, 1890.

Kellock (J. D.) on Carbolic Acid Gangrene.[1]—Some years ago a gentleman brought his daughter, aged nine years, to consult me about an injury which she had sustained in one of her fingers. Whilst playing with a straw-cutter, with other children, the finger had passed between two cog-wheels, bruising the soft parts and bone down to the first joint. The medical man who was called in to dress the wound applied to it some strong carbolic acid and wrapped up the injured part in a rag. On removing the dressing in a day or two the whole finger was completely blackened and withered, in fact, dead. Annoyed at such an unlooked-for result, the child was brought to me, and under the rhigolene spray the finger was removed.

A lady who undertook to decapitate a chicken unfortunately missed her aim, and very nearly severed the end of her left middle finger. The doctor in attendance directed carbolic-acid lotion to be applied. A quantity of the acid poured into a half-teacupful of water formed the wash, saturated with which a rag was bound around the injured finger. The next day, on removing this dressing, the parts which it had enveloped presented a bleached appearance; they were also numb and painless. This was very soon followed by a blackening of the skin and a shrivelling of the whole finger. When I saw the finger five weeks afterward, the line of demarcation was complete, nature's process of amputation slowly going on near the base of the finger. I accordingly anticipated this process by the knife and forceps, and removed the mortified portion.—*Med. News*, May 10, 1890.

Hudson (A. T.) on Veratrum Viride in Tonsillitis. — Tincture of veratrum viride, given before the congestion and inflammation have progressed to molecular impairment, or within twenty-four or thirty-six hours of the beginning, will accomplish this end. The dose is four to five drops given every three hours. Often three or four doses will stop the congestion and produce sweating and permanent relief. Morphine may be added whenever nausea occurs, before the phlogistic symptoms have yielded.

Recently, a strong young man, who had been much exposed to rain and cold, came home at night with a sore throat and painful deglutition. This being the fifth attack, he knew what was the matter; so he struggled through the night, using hot applications and other things as best he could. In the morning I gave him five drops of veratrum viride, with an eighth of a grain of morphine, every three hours. In the evening there was complete relief; and one more dose, the next morning, effected a cure by resolution. It is no assumption to say cure, in place of recovery.

It is pertinent to note that the three former times this patient had had tonsillitis, I treated him with the above plan successfully, with a term of illness not exceeding three to five days each. About a year before this last sickness was the fourth attack. Owing to my absence another physician was called. He evidently had but a slight acquaintance with the virtues of veratrum viride, and did not use it, but he worked faithfully with other things, which gave the patient no relief.

The result was a painful siege of three weeks of confinement, accompanied with a fearful amount of mucus, pus, and dynamic expletives crowding out of his mouth—the old way of relief to such inward fulness. The simplicity of treatment and the promptness of relief are ample reasons for emphasizing the value of veratrum viride in tonsillitis.—*Med. Record*, May 10, 1890.

Crisler (J. A.) on How Iron Acts in Erysipelas.—Erysipelas is essentially a constitutional disease with local manifestation, more or less self-limited, and dependent upon the streptococci erysipelatosi for its existence as a disease.

The most settled fact we have in the limits of bacteriology, is that Fehleisen of

[1] Reprinted from the *Canada Lancet*, March, 1877.

Berlin, in 1883, isolated, proved, and named the above germs; and his statements, observations, and success in isolating the above germs are vouched for by all leading microscopists of Germany as well as other countries.

Fehleisen demonstrated that these microbes if let alone in the blood will not die until they have attacked the tissues and split them up, making the tissue give up its oxygen, and the element itself combines with the nascent oxygen and dies. He further proves that in the zone of infiltration these organisms are dead, and to obtain viable ones it is necessary to go to the area of healthy tissue.

If we accept these statements as facts, there remains but one broken link: since we know that these elements do not die till they are combined with oxygen, and that usually they get the oxygen by the tissue change they produce, the question arises, Does the oxygen that the hematin causes to enter the blood combine with these ptomaines or not?

Certainly it seems plausible, and in fact reasonable, from a chemical standpoint at least. We have that law laid down before us in every object in nature. "Unlikes attract and likes repel each other."

Through the influence of iron (and it is iron alone and not the chlorine in the tincture, for we could not get enough chlorine in the blood to act antiseptically without producing the death of the animal) we crowd into the blood nature's own germicide, oxygen. This oxygen, like that found in the peroxide of hydrogen, comes in with outstretched arms as it were, unsatisfied and surrounded by all the environments necessary to unite with an electropositive element, and it is but the fulfilment of chemical laws when it does unite. Even in plethoric people iron gives only the best results.

Iron should be given first, last, and all the time in this disease. The room should be well aired, and besides, a small quantity of oxygen should be continuously generated therein.—*Memphis Med. Jour.*, April, 1890.

Bredin (S.) on the Bromide of Potash in Tetanus.—A year ago I went to see a colored boy, aged 15. I found him in the third or fourth day of a severe tetanus. His physician was giving him what I supposed was about twenty-five grains of bromide of potassium every third hour. I made no change in his treatment except to prescribe a dose of calomel and leptandrin, and to direct the dose of the bromide to be trebled, and to be given every two hours. He made a rapid and satisfactory recovery. At the end of two weeks he had a relapse, and I prescribed, without seeing him, bromide of potash and chloral hydrate—sixty grains of bromide, and five grains of the chloral—with satisfactory results.

I had previously proved this to be very valuable in the case of a child suffering from tetanic spasms of the severest nature, the result of an extensive burn, which was treated by the application of a forty-grain solution of nitrate of silver, and the internal exhibition of large doses of bromide of potash and three-grain doses of hydrate of chloral. In such conditions as prevail in tetanus ordinary doses but waste time. Treble and quadruple doses are certainly consonant with sound medicine and good common-sense. Such a terrific onslaught must be met with an opposing force of greater power if we are to be physicians then and not triflers.—*University Med. Mag.*, May, 1890.

Bancroft (E. E.) on a Case of Imperforate Rectum.—The patient, an ill-nourished male infant, was two days old when first seen by me. I was called because he had failed to defecate. Superficial examination showed the anus to be normal, and teaspoonful doses of sweet oil were ordered. The next day no movement of the bowels had occurred; the abdomen was moderately distended; the child had begun vomiting, and was in considerable pain. Further examination showed the rectum to be imperforate at a distance of about one inch from the anus.

With a nasal speculum, the child being in the lithotomy position, the imperforate diaphragm across the bowel was brought well into view, and an exploratory puncture made with an ordinary hypodermic syringe, pointing in the direction in which the upper segment of the rectum was supposed to lie; fæces was obtained and a small bistoury was then used, making stellate incisions of reasonable extent. Very copious discharges followed.

The artificial opening was dilated at intervals of a few days, and constipation guarded against by the daily use of sweet oil. After six or seven weeks this treatment was discontinued; and from this

time on the child has flourished (he is now seven months old), and has had normal evacuations, both in consistency and frequency.

The operation was done with cocaine.—*Boston Med. and Surg. Jour.*, May 1, 1890.

Peruvian Balsam not an Irritant to the Kidneys.—In order to find out whether Peruvian balsam exerts any stimulating effect on the secretion of the urine, or whether it irritates the mucous membranes and the kidneys, Drs. Bräntigam and Nowack have carried out a series of minute observations in the Dresden city hospital. These induce them to consider the assertion of Nothnagel and Rossbach, that Peruvian balsam in large doses causes intestinal catarrh and sets up inflammation in the mucous membranes, as incorrect, for though they have given as much as three ounces and a quarter during twenty-four days, they never found any darkening of the urine or any gastric or intestinal disturbance. The largest quantity given in a day was nearly half an ounce. Peruvian balsam does not, it would seem, act like copaiba and storax, since it does not contain an ethereal oil, but only cinnamic acid, benzyl ether of cinnamic acid, and resin. It must, however, be remembered that Peruvian balsam is frequently adulterated with volatile oils, and impure specimens may of course set up a very appreciable amount of inflammation in the kidneys.—*Lancet*, March 15, 1890.

BOOK NOTICES.

Spinal Concussion: Surgically considered as a Cause of Spinal Injury, and neurologically restricted to a certain Symptom Group, for which is suggested the Designation *Erichsen's Disease*, as One Form of the Traumatic Neuroses. By S. V. Clevenger, M.D. With thirty wood engravings. 8vo, pp. iv. to 359. Philadelphia and London, 1889: F. A. Davis, Publisher.

Dr. Clevenger has done good service in bringing together in one volume the writings of many authors upon a complicated subject. He reviews Erichsen and Page, transcribes much of Oppenheim from the original, and gives brief outlines of the opinions of many others, such as Leyden, Westphal, Erb, Putnam, Bramwell, and Knapp, in this way rendering the valuable matter in these scattered pages and monographs readily and quickly accessible. Apart from its obvious usefulness to physicians, and also to lawyers, we cannot refrain from pointing out one or two features which, while not detracting from its serviceableness, tend to somewhat lower its tone as a purely scientific book. A spirit of belligerence prevails in portions of the work which should have no place in a contribution to human knowledge destined to outlive the animosities of a day. It would seem, too, as if a whole chapter devoted to electricity, electro-physics, etc., together with numerous illustrations of batteries now in the market, (the cuts, of course, being furnished by the makers), were somewhat out of place in a work devoted to the subject of spinal concussion. We should like to remodel the sub-title of Dr. Clevenger's book, and even to question his taste in suggesting the name "Erichsen's Disease" for any syndrome whatsoever (there are too many such unscientific landmarks in medical nomenclature already), but the good things of the book so far outbalance the bad that further criticism would appear invidious.

F. P.

The International Medical Annual and Practitioner's Index for 1890.—Edited by P. W. Williams, M.D., Secretary of Staff, assisted by a corps of thirty-six collaborators—European and American—specialists in their several departments. 600 octavo pages. Illustrated. $2.75. E. B. Treat, Publisher, 5 Cooper Union, New York.

The eighth yearly issue of this handy reference one-volume manual is at hand. In its "Alphabetical Index of New Remedies," and its "Dictionary of New Treatment," it richly deserves and perpetuates the well-earned reputation of its predecessors. In this volume its corps of department editors has been largely increased, and important papers upon thermo-therapeutics, electro-therapeutics, sanitary science in city and country, and the medical examiner in life insurance are features of special interest. It is truly a helpful volume, a *résumé* of the year's progress in medicine, keeping the busy practitioner abreast of the times with reference to the medical literature of the world. While there is a generous increase in the size and material, the price remains the same, $2.75.

A New Medical Dictionary: Including all the words and phrases used in medicine, with their proper pronunciation and definitions. Based on recent medical literature. By George M. Gould, B.A., M.D., Ophthalmic Surgeon to the Philadelphia Hospital, and Clinical Chief, Ophthalmological Department, German Hospital, Philadelphia. 8vo, pp. 519. P. Blackiston, Son, & Co., Phila., 1890.

In sharp contradistinction to other recent medical dictionaries, the one under discussion is just the right size for the average medical man. A dictionary in several volumes will do for a library, but what we want is a handy little volume like the present one, which can stand or lie on our desk, take up little room, and yet fill all ordinary requirements. A glance at its pages will convince any one that it deserves, and probably will get, the substantial support of the profession.

Besides ordinary dictionary material, it contains elaborate tables of the bacilli, micrococci, leucomaines, ptomaines, etc., of the arteries, ganglia, muscles, nerves, and plexuses; of weights and measures, thermometers, etc.; and classified tables with analyses of the waters of the mineral springs of the United States, and tables of vital statistics.

THE MEDICAL ANALECTIC AND EPITOME.

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE.

EDITED BY R. W. AMIDON, M.D.

VOL. VII., No. 6. June, 1890. WHOLE No. 158.

THERAPEUTICS.

Regnier (L. R.) on Some New Hypnotics.—A remedy to be a good hypnotic should, according to the author, possess the following qualities:

1st. A dose, comparatively the same for different subjects, should almost without fail in all cases produce sleep sufficiently lasting to be refreshing.

2d. The dose should not be able to produce toxic effects.

3d. The substance should not act on respiration nor on arterial tension to such an extent as to provoke serious accidents (dyspnœa, syncope, chills, collapse):

4th. It should freely eliminate itself and be unable by its accumulation to produce slow poisoning.

5th. The system should not be able to acquire a rapid tolerance of the drug, necessitating an increased and perhaps dangerous amount and a poisonous accumulation of it in the organs.

In this connection the author speaks of several hypnotics, but particularly of acetophenone[1] (hypnone).

This is a clear yellow liquid, sp. gr. 1032, and having a pronounced odor of bitter almonds. It has been favorably reported on as an hypnotic in insomnia due to cerebral excitation, not having much hypnotic action on healthy subjects. In short, to produce sleep in animals, Laborde had to give toxic doses which produced various paralytic phenomena.

The author asserts that the drug modifies nutrition to a marked degree, notably lowers the quantity of hemoglobine in the blood and, by a few days' use, causes an appreciable loss of weight.

He considers it entirely unfit for use.—*Ann. de Therap. Méd.-Chir.*, March, 1890.

Richardson (F. W.). Notes on a Case of Atropia Poisoning.—November 21st, at 10:30 A.M., I drank by mistake some wine from a two-ounce graduate in which had recently been measured a solution of sulphate of atropia, said to have been of a strength of one grain to the ounce, but from the effect produced I am inclined to think it was stronger, or that there was a poor solution. If it was of the strength stated and a perfect solution, there could not have been left in the glass over $\frac{1}{20}$ or $\frac{1}{10}$ of a grain.

In about fifteen or twenty minutes I felt dizzy and was unable to walk straight. This was accompanied by some frontal headache. I had no thought as to its cause, but went into my office, locked the door and lay down. Pulse at this time was ninety and strong.

I soon got up and tried to read. The letters seemed very indistinct, but this did not bother me as much as the confusion of ideas. I would read a sentence, and when at the end of it would forget what it was all about. This was very annoying, and but slow progress was made. This was the last sane act I can remember until about 9 P.M., when it suddenly dawned on me that the office was in great disorder. All movable articles of furniture, books, etc., were strewn promiscously on the floor. I thought for a while that some one had been in, in my supposed absence for supper, and had done this with malicious intent, but on looking in a glass I saw my face was burned and dirty from contact with the stove, which had a

[1] This remedy is really methylphenylacetone, $CH_3COC_6H_5$.

small wood fire, and I began to find bruises all over my body. I then recalled some hallucinations and illusions that had been present. Pictures of animals on the walls seemed to be endowed with their natural movements; strange faces would appear in the room, and I would talk to them a few minutes, when they would be succeeded by others. In attempting to sit down I could seldom strike the chair but would go with full force on the floor, getting in this way a good many bruises. It seemed as though something was constantly in the way, and I would be tripped up at nearly every step taken.

Soon after lying down my throat was somewhat dry, and on regaining consciousness, throat, mouth, and eyes, were painfully dry. I would occasionally hawk up round chunks of inspissated mucus; at one time this caused vomiting. My voice sounded strangely harsh and unnatural. The amount of urine did not seem to be affected, but its passage was controlled with difficulty, and the following day there was some vesical tenesmus. The bowels moved more freely than usual the following day.

My hands were quite œdematous, and tactile and painful impressions were not at all, or but slightly, perceived. Panting respiration at times appeared, but lasted only a minute or two.

From the partial return of consciousness at 9 until midnight I would talk rationally for a few minutes, then would mix in something entirely irrelevant. My gait at this time was very unsteady. I got but little sleep at night, but the next morning felt nearly as well as usual. For two or three days I was unable to read on account of dilated pupils and disordered accommodation. Mouth, eyes, and nose, were very dry for four or five days.

Most of the time during the delirium, seemed to be spent in running around the room, falling down and talking with imaginary people present. I was sensible of no pain except occasionally a little from an unusually severe fall.

There was at no time any eruption.—*North-Western Lancet*, May 15, 1890.

Field (G. P.) on Pilocarpine in Labyrinthine Deafness.—The cases in which the author has found the greatest benefit to accrue are those in which bone conduction had entirely or almost entirely disappeared, where, too, in the majority of instances, the influence of middle-ear disease was subordinate to that of the labyrinth. The treatment has, it is true, appeared to be beneficial in some cases of middle-ear deafness, but not to, by any means, the same extent as in disease of the internal ear. He employs the drug by daily hypodermatic injections.—*Brit. Med. Jour.*, May 17, 1890.

Hare (H. A.) on the Treatment of Insomnia and Neuralgia by Butyl Chloral Hydrate.—Butyl chloral hydrate is little employed in neuralgia in this country, whereas in England Ringer and others had found it decidedly useful in certain cases of insomnia and neuralgia. In a case of neuralgia and insomnia due to middle-ear disease Dr. Hare had found it of decided benefit; five grains in pills every two hours were taken until thirty grains had been administered, after which there was total relief. It had relieved functional insomnia from unknown cause, but did not always respond in insomnia due to advanced systemic conditions. It was beneficial in insomnia due to heart disease, and did not depress the heart. It was especially useful in insomnia with head pain, particularly where branches of the trifacial were affected.—*Med. Record*, May 31, 1890.

Bradfute (C. S.) on the Temperature Reduction in Typhoid Fever.—In a simple case of uncomplicated typhoid fever the writer adopts the following rules regarding hydrotherapy: The patient is sponged with tepid water, containing a little alcohol, twice daily, morning and evening, irrespective of the temperature. If the temperature should reach 104°, simple cold water is substituted, and the patient sponged every half-hour or hour until the temperature falls. It is not necessary to employ antipyretic measures unless the temperature rises to 104°; below that point Nature is fully able to combat it herself. This simple method of reducing the fever has been uniformly successful in the hands of the writer, and he believes, when properly applied, it never fails. Cases with ugly complications are, of course, to be excepted. It may be added that the pleasant sensations and feeling of well-being which occur in a fever patient after a cold sponge bath introduce a physical element which is not without a favorable influence in the course of the malady.—*N. Y. Med. Jour.*, March 8, 1890.

Phenyl-Hydrazin Derivatives as Antipyretics.—Dr. Heinz, who has been engaged in the pharmacological laboratory of the University of Breslau under Professor Filehne, in preparing and examining a number of new phenyl-hydrazin derivatives, finds that they are all, in consequence of their tendency to act as blood poisons, entirely unsuitable for medicinal purposes as antipyretics. He consequently believes that antipyrine, which does not poison the blood, is not a phenyl-hydrazin derivative, although it is prepared from it by first acting upon it by acetic ether and then methylizing the product. He suggests that an entirely new chemical body is formed, from which, rather than from phenyl-hydrazin, antipyrine must be considered a derivative.—*Lancet*, March 8, 1890.

Ferris (A. W.) on Poisoning with Acetanilid.—A lady, aged forty-five, who has suffered from migraine for several years, and who has always experienced relief from the use of antipyrine, had the premonitory feelings which she knows so well one morning last March. Wishing to intercept the attack, she sent for two fifteen-grain powders of antipyrine. Acetanilid was sent to her by mistake, and at 8 A.M. she took one of the powders. She then ate breakfast and attended to her household duties. At 10.30 A.M., her headache having increased, she took the other powder, also of fifteen grains of acetanilid, with about two drachms of whiskey.

She then left the house and drove about the town, making purchases and calling upon several people in the accomplishment of intricate work, in spite of a severe headache. At 12.30 P.M. a friend upon whom she called remarked upon her ghastly appearance, and she hurried home. At 12.45 P.M. she came to me inquiring if she looked strange, and complaining only of considerable pain in her head. I found that her cheeks, naturally warmly tinted, were ashen; her lips, bloodless and shrivelled; her face, haggard and "drawn"; her pulse, 80, and weak. She returned home immediately and took half an ounce of whiskey, ate lunch, and then lay down. At 3 P.M. her face was less pale and her headache had very much increased. She was also feeble and restless, and, on attempting to arise, dizzy and nauseated. Her pulse was 48, and weak; temperature in the mouth, 97° F. She received half an ounce of whiskey and eight minims of tincture of digitalis. Her pulse soon rose to 65. About 5 P.M., the agony from headache demanding relief, and her pulse being over 70, she received ten grains of antipyrine with half an ounce of whiskey; and at 8 P.M. another equal amount of whiskey. She slept well that night and her appetite was unimpaired. The cyanosis and languor passed away entirely during the following afternoon. It was impracticable to examine the urine. There was no vomiting.—*Med. Record*, May 24, 1890.

Nelson (A. W.) on the Topical Treatment of Diphtheria and the Chemical Solution of the Membrane, by Salicylic Acid.—A solvent of the membrane without irritation of the living structures *seems* to be found in the salicylic acid applied dry, much better than the subsulphate, whenever the membrane does not necrose and break down. The subsulphate hardens, in that way killing the acting membrane, rather than acting by solution. Creasote might act well but for its tendency to extend deeply.

The question of destructive action upon bacteria can be affirmed without discussion, and the treatment is considered from a different standpoint.

Hourly use of the acid, which is a very light powder, does not affect the youngest patient unfavorably by the amount swallowed or absorbed.—*Jour. Am. Med. Assn.*, March 22, 1890.

Antisepsine. — Antisepsine or paramonobromacetanelid has been investigated by Professor Cattani. The first effect noted was that in doses of 0.05 grm. four times daily it reduced the temperature from one to two degrees centigrade. Whether employed in the pyrexia of phthisis, pneumonia, or typhoid fever the effects were practically the same. If the dose was large, however, the tendency to produce cyanosis was found to be even greater than with antifebrine. The cyanosis observed was only evanescent however, and was the only unfavorable accompaniment of its administration. The cyanosis is produced in the same way as by antifebrine, namely, as the conversation of hæmoglobia into methæmoglobin. He recommends the inhalation of oxygen in the event of cyanosis occuring. In idiopathic neuralgias the action was tolerably constant, and similar to that obtained by antifebrine, antipyrine, and phenacetine.

The drug was principally remarkable,

however, for the effect of its topical application to non-bleeding wounds, and it was this effect that suggested the name bestowed on it, that of antisepsine. When applied to non-bleeding wounds and ulcers it was observed that rapid improvement took place in the local condition, and especially in the fresher cases, the granulations flattened down, became smaller and disappeared, whilst the antisepsine laid on formed an impermeable layer, under which the violet surface appeared a rose color, in combination with the cicatricial spots which gradually passed on to complete cicatrization. The antisepsine relieved both the pain and itching, whilst the wound passed on to cicatrization with perfect asepticity. He employed it with great benefit in lacerations of the perinæum. In hæmorrhoids, also, the application was very useful as suppuration was avoided, notwithstanding the passing over of fæces. Here it was used in the form of suppository with cacao butter 0.20 to 0.40 to 3.6 to 4.0, that is, suppositories containing 10 to 12 per cent. of antisepsine, and given twice a day, after previous washing out with plain water. Antisepsine is inodorous, which is an advantage in some respects. As it is insoluble in the usual vehicles it must be given internally in capsule or pill, and at least half an hour before or two hours after food. For outward application the form of powder is the most suitable.—*Med. Press*, March 26, 1890.

Davies (J. H.) on Two Cases of Fatal Carbolic Acid Poisoning.—A man of 30 and a boy of 16, drank, instead of beer, some sheep-dip, composed largely of carbolic acid. One patient was in bed, moaning, with his legs drawn up; foam and stains of a yellowish color about the mouth; his pulse could hardly be felt; skin cold and clammy, and the face pallid, and covered with cold sweat; the pupils were contracted, and conjunctivæ congested. There had been free vomiting, and the vomited matter smelt strongly of carbolic acid. The man was in a semi-comatose, and hopeless condition, and could only with great difficulty be got to swallow some olive oil. He had frequent convulsive movements, principally confined to the facial muscles and those of the upper extremities. In the case of the boy, the symptoms were similar, but the coma was not so profound; in his case vomiting had occurred earlier, and this was made more complete by the early administration of mustard and water. In both cases the injected and suffused conjunctivæ and the contracted pupils made a very striking picture. The bailiff died in about six hours after taking the poison, and the lad in about eight hours. The fact that both patients were profoundly under the influence of the poison when first seen, that their mouths and gullets were severely burnt by the acid and the knowledge that both had vomited freely, and milk and oils had been administered, tended to show that the use of the stomach-pump after the lapse of nearly three hours would be productive of more harm than good, so the treatment adopted was the application of warmth, the giving of oil and milk, and a solution of sulphate of soda as an antidote. The boy also had a drachm of ether administered, but its effect was only slight.

A post-mortem examination of the body of the boy was performed on Jan. 2d, forty hours after death, and the features that obtained in his case would apply more or less to the other. There was much post-mortem staining of dependent portions of the body; the rigor mortis was passing off. There were yellowish stains around the mouth, and much frothy mucus about the lips and flowing from the nose. The membranes and vessels of the brain were much congested; the lateral ventricles contained about three drachms of fluid each, which had a faint odor of carbolic acid. The choroid plexus was of a deep purple color. The mucous membrane of the mouth, pharynx, andœsophagus was corroded by the acid, and peeled off readily. The mucous surface of the stomach was of a deep-red color, sodden, and detached in places, and coated with tenacious mucus, with hemorrhagic spots scattered here and there; it contained a little oil and milk and emitted a strong odor of carbolic acid. The small intestine was distended with gas and congested. The liver, kidneys, and especially the spleen, were congested. The bladder contained half an ounce of urine, which was of a greenish color and had the odor of carbolic acid. The pericardium contained half an ounce of fluid which smelt faintly of carbolic acid. The heart's action had been arrested in diastole, the left side being firmly contracted, and the right full of blood which had not coagulated. The larynx was unaffected, the lungs were emphysematous in parts, and the bases

deeply congested. The right lung was almost universally adherent to the chest wall.—*Lancet*, March 8, 1890.

Lemoine on the Toxicity of Boric Acid.—The author narrates three cases in which severe poisoning occurred from large doses of boric acid. There were confluent rubeola-like eruptions on certain parts of the body accompanied by continuous nausea, vomiting, intense headache, and insomnia without elevation of temperature or acceleration of the pulse.

In one case there was a generalized urticaria with vomiting and quiet delirium.

The vomiting and eruption were evidently attempts to eliminate the drug; the other symptoms are of nervous origin. The author thinks toxic symptoms are much more apt to occur in persons with diseased kidneys.—*Bull. Méd. du Nord*, May 9, 1890.

Apostoli and Laquerrière on the Action of the Positive Pole of the Constant Galvanic Current upon Microbes, Especially the Bacteria of Malignant Pustule.—The authors conclude that all bearable currents have no effect on microbes as far as the electricity itself is concerned, but they find that by the passage of strong currents, fifty to thirty milliamperes, for several minutes microbes near the positive pole are killed by the acids there set free.—*La Tribune Méd.*, May 8, 1890.

Truc (H.) on the Treatment of Infectious Phlyctenular Ophthalmia.—The general treatment consists of tonics, iodides, hydrotherapy, sojourn in country, and sea-bathing; the regional treatment consists of antisepsis of eruptive foci, of the entire integument, the hair, the nails, the clothing, and surroundings, while locally borax eyewashes, cocaine, atropine, yellow precipitate, etc., are useful.—*Gaz. Hebd. des Sci. Méd., de Montpellier*, April 26, 1890.

Brocq on an Ulcerated Epithelioma of the Face Rapidly Healed Over by the Powder of Aristol.[1]—A man of fifty had a large ulcerating epithelioma of the left side of the face, involving the upper lip, the naso-labial fold, the left side of the nose, the region of the lower lid, which was completely destroyed, and the malar prominence. All other applications had failed, and it was sprinkled with aristol in the form of a powder. The effect was almost immediate. In five or six days cicatrization, starting from the centre of the ulcer, had progressed with great rapidity. After twenty daily applications and two light scrapings cicatrization was all but complete.

The drug causes no pain, seems so far non-toxic, and has no bad odor. — *La France Méd.*, May 2, 1890.

Reichert (E. T.) on the Action of Caffeine on the Circulation. — The pulse-rate may be diminished during the first and last stages of the poisoning, but is generally decidedly increased. During the first stage the diminution is due to a stimulation of the cardio-inhibitory centres in the medulla oblongata and heart, and during the last stage to a direct depression of the heart. The increase in the pulse-rate is due to a depression or paralysis of the above cardio-inhibitory centres.

Arterial pressure during the first stages of poisoning is generally unaffected or diminished, but occasionally a trifling increase is noted; during subsequent stages it is diminished. The increase is due to a direct stimulant action upon the blood-vessel walls, increasing vascular tension. The diminution is due chiefly to a direct depression of the heart, and to some extent, doubtless, to a secondary paralysant action on the vessel walls.

The acceleration of the heart-beats may be accompanied by no appreciable alteration in blood-pressure, but generally by a more or less decided diminution, which is dependent upon cardiac depression.

Caffeine diminishes the heart's efficiency for work, arrests it in diastole, sometimes induces sudden paralysis, and is, therefore, a cardiac depressant.

The asserted stimulant action upon the circulation is, doubtless, subjective, and dependent upon an excitation of the cerebral centres.—*Therap. Gaz.*, May 15, 1890.

Bovet on Anemonine from a Therapeutic Point of View.—After referring to the effect of anemonine in raising arterial tension and its successful use in gonorrhœal orchitis, the author narrates his experiences with the use of the drug in various painful uterine affections. There were twenty-two cases of painful dysmenorrhœa, two cases of uterine prolapse, two of ovaro-salpingitis, and two of fungous endo-metritis treated by doses of anemonine varying from gr. i to gr. iii daily. In all cases amenable to medicinal

[1] Aristol is the biniodide of dithymol.

treatment recovery supervened, in those pertaining to the domain of surgery it acted as a powerful sedative, showing it to be a useful adjuvant to surgery.—*La Tribune Méd.*, May 15, 1890.

Fackler (G.) on Calomel as a Diuretic.—The author's conclusions are as follows: 1. Calomel. and, in all probability, other mercurial compounds, possess diuretic action. 2. If given in proper doses the effect of calomel becomes evident from the second to the tenth day. Continuation of the treatment during diuresis will not alter or increase the effect. 3. Its action is most marked in dropsies due to heart disease. Its action in dropsies of hepatic origin is not to be relied upon. Pathological changes in the kidney prevent or abridge its action. 4. Small doses are of no avail. 5. The diuretic action, in all probability, is due to the irritating effect which mercury exercises during elimination upon the renal epithelium.—*Med. Record*, March 31, 1890.

Smith (P.) on Acute Universal Desquamative Dermatitis Following the Administration of Chloralamide.—The patient, a man aged forty, suffering from aneurism, was, among other hypnotics, prescribed chloralamide in full dose, and with apparently good effect. Soon after acute inflammation appeared on the face with coryza, stomatitis, and raised temperature; this rapidly spread over the whole body, the urine was febrile and slightly albuminous, and pyrexia continued for a week. Profuse desquamation followed, resembling that of exfoliative dermatitis, and the skin finally resumed its normal appearance.—*Med. Press*, March 5, 1890.

Strychnine as the Antidote in all Cases of Alcoholism and its Associate Diseases.—According to the writer, in cases of acute, subacute, and chronic alcoholism, about a third of these cases being associated with delirium tremens, strychnine will supply every want. Nearly all suffering more or less from anorexia and troubled with nausea. Some have come in shaking from head to foot, miserable from loss of appetite, and, at times, wild with the delirium. These same unfortunate people leave a few days later freed from all such symptoms.

The usual plan of treatment was as follows: Upon admission a thirtieth (1-30) of a grain of the sulphate of strychnia was injected hypodermically, increasing the dose one third every three hours, until it was equal to a tenth. This being the maximum dose, it was given three times daily, though as much as a sixth of a grain has been given at once. As soon as the patient convalesced the same dose was continued by the mouth. There can be no fixed rule for this treatment. One should be guided by the symptoms that present themselves. —*New Orleans Med. and Surg. Jour.*, May, 1890.

Chloralimide.—M. Choay has succeeded, in collaboration with M. Béhal, in preparing a chemical compound which is destined, perhaps, to replace chloral hydrate. This body is chloralimide, which answers to the formula CCl_3CHNH. It chrystallizes in long needles, and is colorless, odorless, and tasteless. It is insoluble in water, but soluble in alcohol, ether, chloroform, and fatty matters. Chloralimide must not be confounded with the other new hypnotic chloralamide, which has improperly received this name, for chemically speaking it is "chloral foramide." M. Choay considers that the activity of chloralimide will surpass that of chloralamide, seeing that for equal weight it gives more chloroform. It has no disagreeable taste and is permanent, while chloralamide is decomposed by a temperature of 60° C. The dose is the same as chloral hydrate.—*Br. Med. Jour.*, May 17, 1890.

Monod (C.) on the Treatment of Rebellious Constipation by Forced Dilatation of the Anus.—The first case in which the author employed this measure was a dyspeptic woman of forty-five, subject to alternate constipation and diarrhœa, and in whom the intestinal trouble was thought to depend on some abdominal tumor. Careful examination revealed simply fæcal impaction. The author anæsthetized the patient, instrumentally dilated the anus, and, with the fingers, removed an enormous amount of fæcal material. A laxative completed the evacuation and the constipation did not return. He has since employed this method successfully in many similar cases.

He thinks the constipated habit in these cases is inaugurated by the spasmodic contraction of the sphincter, which, by its resistance, gradually tires out and weakens the propulsive and expulsive power of the gut higher up. By removing this impediment a chance is given the bowel to regain this power and resume its normal function. —*Ann. de Therap. Med.-Chir.*, March, 1890.

Duncan (P. J.) on a Case of HCl Poisoning. Fatal on the 94th Day.—A man of thirty-seven accidentally swallowed part of an ounce of fuming HCl. Post-mortem examination showed general contraction of the stomach. The mucous membrane near the pylorus presented several cicatrices, and the pylorus and adjacent gastric wall were so thickened and firmly contracted, and the opening so constricted, as only to allow the passage of the knob of a large probe. All the other structures were healthy.

The mouth, fauces, and œsophagus entirely escaped harm, while the pyloric region of the stomach suffered. Seeing that the stomach was probably empty at the time of taking the corrosive (the patient having taken no breakfast), the fact that the pylorus was the only part injured might be taken as confirmatory evidence of Dr. Lesshaft's views as to the almost vertical position of the fasting organ. A point of the greatest interest was the apparent separation of the sloughs from the eighth to the tenth day, as evidenced by the alarming hemorrhage. Had any food been allowed by the mouth the bleeding would certainly have been ascribed to it. This case, then, proves the absolute necessity of withholding food by the mouth until this period is safely passed, however urgent the craving and however quiet the symptoms. The complete healing of the ulcerated surfaces was accomplished by about the twentieth to the twenty-fifth day, *i.e.*, ten to fifteen days after the separation of the sloughs. This might serve as an indication of the shortest time during which it is of use to keep a case of active gastric ulcer on rectal alimentation; though it is no guide to the further length of time required, as it is reasonable to suppose that the mucous membrane in gastric ulcer, being in a less healthy condition, would require a longer period for processes of repair to be accomplished. The unfortunate situation of the chief lesions around the pyloric orifice led to a second train of symptoms; and it is to be regretted that at the time of the operation it was found impossible to reach the orifice, owing to its extreme stenosis, as dilatation of the stricture, excision of the pylorus, or the establishment of a gastro-duodena fistula would apparently, if successful, have effected a cure. There is another point worthy of notice in the history, viz., that on the first admission the patient had increased pain on lying on the right side, where later experience showed the lesions to have been.—*Lancet*, April 12, 1890.

Mettler (L. H.) on Cocillaña and its Clinical Uses.—In its first effect cocillaña seems to be a stimulant expectorant, for the cough, from our observation, has always been increased somewhat at first, as well as the expectoration. But as its action continues it becomes a sedative, and by overstimulation diminishes the expectoration. This is shown clinically as well as by physiological experiment. Though it acts upon the alimentary mucous membrane, causing emesis and catharsis, when administered in high dosage, this does not interfere with its employment as an expectorant, since the dose necessary for the latter purpose is quite below that required to produce marked nausea and diarrhœa. Its occasional mild cathartic action when administered for its expectorant effects is highly advantageous, and nausea need not be feared unless injudicious dosage be employed.

We have noticed a feeling of weakness and depression occasionally following the use of full doses. This, together with the fact that it is a stimulant, particularly in the form of the tincture, leads us to contra-indicate it in phthisis and all those pulmonary affections having associated with them marked emaciation and debility. In the acute affections of the air-passages cocillaña should never be employed in the earlier stages when the mucous membranes are engorged and the cough is merely of an irritative sort, without expectoration. As soon, however, as the period of exudation arrives, usually from a week to two weeks from the subsidence of the acute inflammatory symptoms — in a word, when the trouble is about becoming sub-acute, the use of full doses of the drug will give the happiest results. In the chronic forms of bronchitis, when there is an expectoration that is scanty, thick, and tenacious, the best results have been secured and positive cures obtained. In capillary bronchitis and in the chronic forms of broncho-pneumonia, cocillaña fails to give uniform relief, and for these we still retain our preference for the ammonia salts. We prefer the fluid extract to the concentrated tincture, both for its smaller dosage and greater uniformity of action. In regard to the dose, it will be noticed that we have used ten

drops, sometimes fifteen, of the fluid extract every three or four hours. This would be an average, though we have no doubt but that some cases might bear even twenty or twenty-five drops. Nausea would be the proper indication that the maximum dose for a certain individual had been reached; hence, in some cases we have ordered the patient to increase the quantity until this effect was first noticed. As the physiological activity of the drug seems to terminate in about six hours, we have ordered and obtained the greatest benefits with the doses taken from three to four hours apart. We believe that in cocillaña we have a valuable addition to our materia medica. Of the drugs with which we are already familiar, it resembles most nearly ipecacuanha, and yet its action is sufficiently unlike that of the latter to warrant its being considered a remedy *sui generis*.—*N. Y. Med. Jour.*, April 5, 1890.

The Treatment of Phthisis by Carbonic Acid.—It is said that lime-burners enjoy a certain degree of immunity from phthisis, not because they take in more carbonic acid, but because its diffusion when expired is impeded. Again, the course of phthisis is often seen to be arrested in pregnancy, and this has been ascribed to the increased amount of CO_2 in the maternal blood. Chronic heart disease, by causing chronic hyperæmia of the lungs, also affords a kind of immunity against phthisis; lastly, in emphysema there is also permanent dyspnœa in more or less degree, and the blood is overcharged with CO_2. Acting on these ideas, Dr. Hugo Weber (St. Johann-Saarbrücken) proposes to administer CO_2 by the stomach, in the form of effervescing powders. Ten cases are reported in which decided improvement was noted after this treatment, which certainly merits further trial, especially as it can be carried out at patients' own homes. According to Ebstein's theory of diabetes, the increased proneness to phthisis which that disease entails is due to the defective development of CO_2, this being not only the final product of tissue oxidation, but a body which exerts a regulatory restraining influence on the destruction of glycogen and albuminoids. Bergeon, Dujardin-Beaumetz and others have used in phthisis gaseous injections *per rectum* of hydrofluoric acid, copiously diluted with CO_2, and the good results they met with are claimed by Dr. H. Weber as due to the diluent.—From *Berliner klin. Wochenschrift*, No. 35, 1889, in *Brit. Med. Jour.*, March 8, 1890.

Shurley (E. L.) on The Local Treatment of Phthisis Pulmonalis.—The author has found by experiments on guinea-pigs, etc., that medicated inhalation, administered in a small room, frequently and for some time, left a deposit of the drug in the finer bronchi; not so when the inhalations were in larger rooms in which the air could not be saturated. These facts corresponded with clinical experience in the case of man. Inhalations by ordinary means employed by patients at their homes were of little value except where the process was confined to the upper air-passages. He thought it unreasonable to expect benefit from air passing over a sponge containing a few drops of creasote. In brief, he thought the profession should discard the ordinary inefficient means of using medicated inhalations, when it was desired they should reach the air-vesicles, and confine the patient to a room in which the atmosphere was saturated, or seek some other efficient method.—*Med. Record*, May 31, 1890.

Maxwell (T.) on the Inhalation of Bromide of Ammonium Fumes.—At first the author employed a chloride of ammonium inhaler, substituting solutions of hydrobromic acid for hydrochloric acid. He found it impossible to keep the fumes neutral and the hydrobromic acid present irritating. He finally resorted to an apparatus by which the bromide of ammonium was vaporized by heat. He has used the bromide in true asthma, and finds that if inhaled just as the attack is coming on it will frequently avert it entirely. He is disposed to think that the inhalation of bromide of ammonium fumes will prove of great benefit to many sufferers from various forms of asthma.—*Lancet*, May 10, 1890.

Rare Form of Iodism.—An important contribution to the *Therapeutische Monatsch.*, March, 1890, is made by Dr. A. Groenow, of Breslau, on a rare form of iodism with acute œdema of the glottis. In all he refers to nine cases; two are from his own practice, the remainder are reported by Foerster, Fournier, Fenwick, and Malachowski. On reviewing these several cases the author draws the following conclusions: 1. That the œdema,

which is sudden in its arising, takes place early in the administration of the drug, generally within twenty-four to forty-eight hours, and that its intensity may be such as to call for tracheotomy. 2. That the quantity requisite to call forth the symptoms varies from the lower limit of three grains upwards; in one case, though there were slight throat symptoms earlier, yet it was not till the sixth day, when about two hundred grains had been taken in all, that severe dyspnœa set in. 3. That other symptoms of iodism may be quite absent. 4. That the cause of these exceptional effects is not the presence of impurities (iodates), but that the pure drug is alone sufficient. 5. That local laryngeal affections could not be shown to be present and to have predisposed the part to the œdematous outbreak. 6. That the phenomena must be explained by the word idiosyncrasy. 7. That in some cases the idiosyncrasy persists, but that in others it rapidly disappears, the patient becoming tolerant of the drug. The author lays stress on the fact that it is during the early part of an iodide course that this trouble is most likely to arise, and that watchfulness during this stage may avert a dangerous complication.—*Brit. Med. Jour.*, May 10, 1890.

Cantharides Plaster.—A correspondent who states that under proper precautions he has been able to procure a beautiful crop of micrococcus pyogenes aureus, or staphylococcus pyogenes aureus of Rosenbach, in a tube of sterilized nutrient fluid inoculated with material drawn from a cantharides plaster. As a result, our correspondent thought himself justified in giving a general warning to wholesale chemists on the importance of taking heed "where they get their ingredients to prepare fly blisters with." It is well known that troublesome pustulation frequently follows the application of cantharides plaster, and the presence of the micrococcus is extremely suggestive, whatever its ultimate source may be found to be. The question is too important to be allowed to resolve itself into an attack upon wholesale chemists; indeed, this would be manifestly unjust upon the very scanty data supplied. Nevertheless it is to be hoped that they will decide whether it is ever desirable to employ powdered cantharides in preference to liquid preparations.—*Lancet*, May 10, 1890.

Trinquart on Permanganate of Potassium in Pills.—The author uses only inorganic constituents in compounding his pills of permanganate of potassium. He takes permanganate of potassium gr. xv., carbonate of magnesia gr. viiss, and triturates the ingredients finely in a marble mortar previously thoroughly cleansed with alcohol and distilled water. He then adds, little by little, the hydrated sesquioxide of iron, freshly made, washed with distilled water and lightly squeezed in a cloth in a way to make a pill mass of good consistency, which should be promptly divided into ten pills. The pills should be dried in the open air and put in a box containing a small amount of powdered carbonate of magnesia.

Another process the author employs is as follows: He takes gr. xv. of permanganate of potash and pulverizes it in a scrupulously cleansed mortar. He takes the washed precipitate formed by adding nitric acid to a solution of the silicate of potash and adds it little by little to the permanganate to make a soft mass, which is divided into ten pills.

These pills are permanent because they contain no organic ingredient. They are not too hard and dissolve readily in water. —*Union Méd. du Nord-est*, April, 1890.

Dudley (W. H.) on Fatal Podophyllin Poisoning.—I was called to see Mrs. O——, aged sixty, at 1 A.M., September 11, 1889, and found her in the following condition: Face, feet, and hands quite cool; cold perspiration standing on face; pulse 60, quite weak and thready; respirations sighing, and speaks with difficulty. Says she took some mandrake the evening before, and soon afterward (about 10 P.M.) commenced vomiting and purging, which continued to the present. Both vomited matter and stools contained bile. Two hours later the vomiting and purging had ceased, the pulse rose to 70 per minute, the hands and feet getting warm, respirations were natural, and the patient expressed herself as being comparatively comfortable. About seven o'clock in the morning the patient felt so far recovered that she arose and dressed, but soon lay down, feeling quite depressed. Her mind now showed aberration, and memory of past events quite defective. Seen at 3 P.M.: Primary symptoms of depression returned, but no purging or vomiting.

At 9 P.M. of the same day (about twenty-

four hours after taking the podophyllin) the patient was comatose; pulse 100 to the minute, full, soft, and compressible; temperature, 100° + F.; pupils slightly contracted; respiration, 38. The hand applied to the surface would suggest a higher temperature than is shown by the thermometer.

From this time till 4 A.M. of the morning of the 14th there was a gradual decline. Occasionally she would arouse sufficiently to take food and remedies, but was, for the most part, comatose. The urine had to be drawn, and was found to be smoky in color; specific gravity, 1.020, acid; albumen one eighth volume after standing; microscope showed large quantities of blood-cells, but no casts were discovered. In this case there was an error in the patient's dose. She supposed she was taking mandrake, while she took its resinoid, podophyllin. The quantity taken, as shown by the patient before her mind became clouded, was found to weigh about five grains. In this case the treatment consisted of, at first, morphia, one eighth grain, followed by small quantities of whiskey; later, of food and stimulants, as it was possible to exhibit them.

The primary symptoms of poisoning were removed rather promptly when the condition of the patient promised recovery, but those developing later showed an unrecorded secondary action which would suggest that the liver had been stimulated to the production of a large amount of cholic, choleic, taurocholic, or glycocholic acid, the effect of which was to bring about a condition similar to that of cholæmia, minus the jaundice, a symptom absent throughout the duration of the illness—about eighty hours. No post-mortem was obtained. It should be stated that the husband of the patient took a similar dose of the same drug, and suffered primarily in about the same manner as his wife, though in a minor degree, which was followed by a depressed condition for two or three weeks, but finally recovered and has since enjoyed his usual health.—*Med. Record*, April 12, 1890.

The Bath Treatment of Typhoid.—The system of cold baths in the treatment of typhoid fever as employed in Germany has been put to the test by Dr. Josias, and he reported to the Société des Hôpitaux that during the years 1888 and 1889 he treated thirty-six cases of typhoid fever by cold baths—that is to say, with water at 18° C., repeating these every three hours. Of 36 cases the experimenter obtained 35 recoveries. Drs. Renoy and Richland, who, on their side, had followed this method, obtained 103 recoveries out of 108 cases. Dr. Merklen, on the other hand, in a report on the mortality caused by typhoid fever in the hospitals of Paris, showed that this mortality fluctuated between 14 and 15 per cent. In another report by Dr. Sorel, the author stated that out of 105 cases of typhoid fever, he obtained 100 recoveries, and five cases proved fatal. The treatment consisted in prescribing the sulphate of quinine associated with the salicylate of soda. Some of the patients had taken baths, but rather warm than cold. Dr. Sorel does not believe that in present circumstances the superiority of cold baths is sufficiently well established to make a method of treatment obligatory in the French army, as it is in the German army. A French critic, writing on the cold-water system of the treatment of typhoid fever in Germany, gives the following statistics, drawn up by Dr. Longuet, relative to the German army, which may be found interesting here. In 1865, out of 2,500 typhoid patients, there were from 500 to 700 deaths. From 1882 to 1884, the number of patients was nearly identical; but, thanks to the application of the cold baths, the deaths among the soldiers amounted on the one hand to 221, and to 183 on the other. Since then the diminution of the mortality was slow, constant, and mathematical, according as the cold-water system extended. From 24 per cent. in 1865, the mortality fell to 11 per cent. in 1876. In 1883 it was not more than 9 per cent. These figures were thought by the writer to be conclusive on the subject, and he asked why the French were obstinate and remained behind in this matter.—*Lancet*, March 8, 1890.

Williams (A. D.) on Lunar Caustic in Bleeding Otorrhœa.—A few days ago I began to treat a boy, who had had otorrhœa from one ear for a long time. The discharge was profuse and extremely offensive. The history showed that the ear often bled quite freely. Any disturbance of the ear, as by wiping or washing, caused more or less bleeding. I was not surprised to see considerable hemorrhage when I syringed the organ, but was much surprised at the persistency of the bleeding. I would wipe it out with cotton and the blood

would at once well up from the bottom, filling the meatus in a few moments. After wiping out the blood repeatedly and not noticing any diminution, I twisted a little cotton on the end of a probe, stuck it into a strong solution of lunar caustic (30 grains to ounce), and, passing it down to the bottom of the ear, gently swabbed it around. This stopped the hemorrhage at once. When I removed the blood, clotted and blackened by the remedy, I found extensive soft fungous granulations filling the drum-space, the membrane having been destroyed. These I cauterized still more freely by shaving down a stick of caustic, twisting cotton on the probe, wetting it, touching it to the powdered caustic, and then touching it directly to the fungous granulations. After syringing the ear next day I discovered a small polypus projecting from one side of the drum. This I touched with a particle of chromic acid by means of a stick, and applied boracic acid in the usual way. All suppuration ceased within three days. This is a very rapid cure of that kind of trouble. Lunar caustic is a most valuable remedy in bleeding otorrhœa. The cause of the hemorrhage is always fungous or polypoid growths. The caustic causes practically no pain.—*St. Louis Med. and Surg. Jour.*, May, 1890.

MEDICINE.

Müller (E.) on Sudden Death from Introduction of Milk into the Air Passages.—The patient, a child of five months, was pretty well except that at night it breathed rather heavily when on its back.

One morning, after nursing, the sleeping child was put upon a cushion. The nurse, looking at the child, thought it smiling, then grimacing as if in pain, and suddenly it turned blue. It frothed at the mouth and stopped breathing. All efforts at resuscitation proved unavailing.

On autopsy, the thymus was found to be unusually large, the larynx, trachea, and all the bronchi on the right side were found filled with milk. The heart and brain were normal.—*Gaz. Méd. de Strasbourg*, April 1, 1890.

Cassaet on the Entrance of Air into the Veins in Tracheotomy.—Without recourse to anæsthesia, the author performed tracheotomy on a man of twenty-nine in the third stage of pulmonary tuberculosis with laryngeal stenosis and suffocative attacks. During the operation a large vein was opened, and before it could be secured two inspirations occurred, and, judging by the characteristic hissing sounds, considerable air must have been sucked in.

The indifference of the patient permitted a complete auscultation of the heart with very interesting results.

There was heard over an area of about ten centimetres, the centre of which was the tricuspid region, a very pronounced hydro-aërial bruit, a gurgling of a metallic timbre synchronous with the systole. This zone appeared to increase sensibly in extent the minutes which followed the entrance of air and the commencement of the ausculation, the bubbles becoming more numerous and larger. The hydro-aërial bruit became more and more limited to the tricuspid area and the bubbles diminished little by little in volume, the gurgling changing by successive stages into a fine subcrepitant râle. The bubbling disappeared after twenty-five minutes.

The dyspnœa was not intense, and the pulse, at first small, soft, and compressible, recovered itself as the gurgling disappeared.

It was at the expiration of twenty-five minutes that the patient showed some signs of asphyxia, slight cyanosis, smallness of the pulse, chilliness, sweats, and an apnœa which yielded immediately to an electrical application. The operation was then completed. A little relief followed the introduction of the canula. Three hours later the patient insisted on getting into a chair, and suddenly expired.

An autopsy revealed various tubercular lesions of the larynx, trachea, and lungs and distension of the heart by a clot and distension of the arteries and veins by dark blood without froth.—*Gaz. Hebd. des Sci. Méd. de Bordeaux*, May 4, 1890.

Loomis (H. P.) on Tubercle Bacilli Found in the Bronchial Glands of Non-Tubercular Subjects.—A rapidly fatal case of disseminated tuberculosis in which the infective focus seemed to be a bronchial gland, led the author to make further examinations with the following results:

Six out of the fifteen persons in whom autopsies were made had in their bronchial glands active tubercle bacilli. None of the persons presented any evidence of old or

recent tubercular processes, yet the bacilli were within the bronchial glands, ready to enter the general lymphatic system of the lungs and set up a localized pulmonary tuberculosis, or by entering the general lymph or blood current, give rise to a general tuberculosis.

It has been demonstrated that tubercular bacilli may be inhaled in respired air. The position of the bronchial glands, and the arrangement of the lymphatics in the respiratory tracts, render it easier for the inhaled tubercular bacilli to enter them than the lung parenchyma, for it is to be remembered, that just beneath the mucous membrane of the lower portion of the trachea and the mucous surface of all the bronchi, is an immense network of lymphatic vessels, running directly into the bronchial glands, which are situated between the right and left bronchi, and along the first divisions of the bronchial tubes, as they pass into the lungs. On the mucous surface of the trachea and larger bronchi, the tubercle bacilli would be more liable to lodge, than to be carried down to the pulmonary alveoli. If the integrity of these mucous surfaces is weakened, as occurs during mild attacks of bronchial catarrh, the direct passage of the tubercle bacilli into the bronchial glands would be favored. As is indicated by the cases reported above, the tubercle bacilli may remain quiescent in this situation for an indefinite period, but still retain all their virulence.

While these experiments establish the fact that tubercle bacilli gain entrance into the bronchial glands of perfectly healthy persons, and apparently remain quiescent in them for an indefinite period, further experimentation is necessary to determine if other glands, such as the axillary, inguinal, etc., of healthy persons, may not also be the resting-place of bacilli, from which they may at any time, when the vital power of the blood is lowered, pass into the general or lymphatic circulation and cause local or general tuberculosis.—*Researches of the Loomis Laboratory*, No. 1, 1890.

Chantemesse and Vidal on Pleurisy in the Roseolic Stage of Syphilis.—Synovitis is not such a rare manifestation at the outset of the second stage of syphilis, but pleurisy is uncommon.

A woman, of twenty-nine, developed in September a general syphilitic roseola. On admission, January 29th, she had mucous patches in the throat, some general syphilides, pains in the joints, and a not very abundant pleuritic exudation. In February she had a syphilitic iritis. The pleuritic exudation had disappeared in April.

Another woman, of forty-five, had the primary lesion in January. On admission, February 20th, she had a general syphilitic roseola, mucous patches in the mouth, and a dry pleurisy at the base of the left lung. All manifestations disappeared under mixed treatment.—*La France Méd.*, April 25, 1890.

Tilmans on Removal of the Lung in a Long-Standing Case of Empyema.—The patient was a man, with an empyema of two years' duration. Much benefit had followed two resections. A third attempt having failed completely, it was decided to lay bare a large pleural surface by a free costal resection, and scrape it thoroughly. Two days after the operation, skin was transplanted after Thiersch's method, and quite rapid healing resulted.

The left lung had completely disappeared. In somewhat similar cases, where a small stump of lung remains, the author favors its removal.—*La Tribune Méd.*, May 15, 1890.

Hay (C. M.) on Hereditary Chorea, with a Contribution of Eight Additional Cases of the Disease.—The characteristic features of this disease may be stated to be as follows:

1. The disease is directly hereditary, and frequently runs through four and five successive generations.

2. Usually it begins in adult life, between the ages of thirty and fifty years, but exceptions to this are frequent.

3. There is a very strong tendency to mental disease of some degree, and suicide is common in the affected families.

4. In the great majority of cases it begins insidiously in an upper extremity without any marked premonitory symptoms, but in some cases mental disturbance has preceded its onset.

5. The movements more or less rapidly become general and get progressively more marked, some cases dying from the consequent disability, especially of taking sufficient nourishment. Emotion increases the chorea, which is considerably under the control of the will. Speech and the power of writing are impaired early and lost in the last stages of the disease. The knee-jerk is usually exaggerated, and ankle-

clonus is present in some cases, while the condition of the heart has been noted in few of the cases. Epilepsy and phthisis are frequent in the affected families, and the former may coexist with the disease.

All writers have agreed that the treatment of hereditary chorea is purely palliative, and no remedy has been found to give more than a temporary relief, by diminishing to a slight degree the severity of the movements. In my own cases I have at different times used full and continuous doses of iron, arsenic, hyoscine, hyoscyamine, the bromides, sulphonal, and many other drugs. No permanent good resulted in any case under any of the various treatments employed, and I have found that the drugs which possess some power in arresting the movements have to be given in doses sufficient to cause marked gastro-intestinal disorder, and therefore conclude that treatment by powerful depresso-motor and antispasmodic remedies is not justifiable in this affection. The regulation of the general bodily functions and the avoidance of excitement or anxiety, with tonic and nutritive measures—if indicated by the condition of the patient—would seem to be the best treatment in fully-developed cases, while, as Dr. Wharton Sinkler has pointed out, the same prophylactic precautions should be employed in those liable to the disease as should be used in cases predisposed to insanity. After the disease has developed these means should be more vigilantly attended to, in order, if possible, to avert the mental doom which finally overtakes such a large percentage of these cases.—*University Med. Mag.*, June, 1890.

Monomania in Stealing.—A curious series of facts supplied to Dr. Peddie by the late Sheriff Barclay, of Perth, exemplifies phases of crime related to habitual drunkenness and to proclivities indicating insanity: "Between the years 1844 and 1865 one woman was committed to prison 167 times for being drunk, and when drunk her invariable practice was to smash windows. Then there was a man who, when drunk, stole nothing but Bibles; he was an old soldier, wounded in the head; when drunk, the objects of theft were always Bibles, and he was transported for the seventh act of Bible stealing. Then another man stole nothing but spades; a woman stole nothing but shoes; another nothing but shawls; and there was a curious case (the indictment against whom I have) of a man, named Grubb, who was transported for the seventh act of stealing a tub. There was nothing in his line of life and nothing in his prospect, no motive, to make him specially desire tubs; but so it was, that when he stole it was always, excepting on one occasion, a tub."—*Br. Med. Jour.*, May 10, 1890.

Veslin (L.) and Feulard (H.) on Extra Genital Chancres.—The authors have observed in all sixty-four extra-genital chancres, which are thus classified according to location:

Chancres of the	upper lip,	9
" "	lower "	19
" "	labial commissure,	1
" "	tongue,	5
" "	tonsil,	5
" "	eyelid,	1
" "	chin,	2
" "	breast,	7
" "	abdomen,	3
" "	umbilicus,	1
" "	anus,	5
" "	limbs,	4
" "	fingers,	3

—*Annales de Dermat. et de Syph.*, April 25, 1890.

Stirling (R. A.) on a Case of Syphilis from Tattooing.—In the following case of tattooing, in which the patient was inoculated in three different sittings, by the salivary secretions of a friend, there can be no doubt that at the time the operator was free from any ulcerative lesion in the mouth, though undoubtedly suffering from an annular syphilide on the body— a rather late form of eruption—as well as the peculiar deep red staining on each side of the nose, which is so frequently found in long-standing forms of the disease, especially in those who drink rather freely.

The figure to be tattooed was a wreath of flowers, and exactly twenty-three days after its first commencement, there appeared on the upper angles of each end a small ulcer. The wreath was in six separate parts, and the six points of inoculation took within forty-eight hours of each other. It is notable, that the subsequent ulceration never extended beyond the bounds of the original wreath.

When A. presented himself at the out-patient room on the 15th of February, there were six large ulcers, together forming a horseshoe, situated on the outer surface of the left arm, the upper margins

commencing at the insertion of the deltoid, and extending a distance of three inches, with a width of two and a half inches. The ulcers were separated from each other by thin bands of undermined skin. Their edges were not indurated; rather clean cut, and the bases studded with rather flabby granulations, exuding ordinary pus. There was no pain, and during the period of incubation, he appears to have felt no inconvenience. The ulcers enclosed an Italy-shaped piece of skin, upon which he himself had tattooed a flower, but there was no trace of any ulceration, merely the mark of the ink.

There was a hard "bullety" gland in the left axilla. A maculous syphilide was well distributed on the body, and the fauces and veil of the palate were red, and slightly swollen. The patient at the time was suffering from gonorrhœa, but never had a sore on the genitals, nor was there any cicatrix there, nor enlargement of the inguinal ganglia.—*Australian Med. Jour.*, March 15, 1890.

Crivelli on Precocious Genital Development in a Girl of Eighteen Months.—The girl, eighteen months of age, was about 32¼ inches in height, but had disproportionately wide hips and waddled in walking. The chest was well developed, the breasts being those of a girl of fifteen or sixteen years and the erectile tissue of the nipple was equally well developed. The mons veneris was prominent and covered with a thick down. The clitoris was relatively enormous and apparently the seat of voluptuous sensations. The vulva was moist and the parts red and inflamed and the clitoris turgescent.

The child had menstruated three times at regular intervals. In all other respects the child was like others of her age.—*La Tribune Méd.*, May 15, 1890.

Sloughing of the Bladder.—Two monographs on this formidable accident have recently been prepared by Dr. F. W. N. Haultain. One appeared in the *British Gynæcological Journal*, the other being a very complete scientific report entitled "Necrosis of the Bladder: its Pathology, Ætology, and Course," which was published in the second volume of *Laboratory Reports*, issued by the Royal College of Physicians, Edinburgh. The protrusion of the whole or part of the mucous membrane of the bladder from the urethra is a most alarming symptom, and the practitioner will naturally wish to know what is likely to result from the exfoliation, and what ought to be done. Hence we may note Dr. Haultain's observations on "prognosis"; out of fifty-three collected cases of necrosis of the bladder in the female, but twenty-five ended fatally; in twenty-nine exfoliation took place, with only eleven deaths, an almost incredibly low percentage, especially when it is taken into consideration that in at least six of the recoveries the entire thickness of the bladder wall was cast off, portions of peritoneum being found on the external surface of the sac. The prognosis as to complete recovery and restoration of the bladder to its normal functions is less favorable. In the large majority of cases, more or less incontinence of urine was observed. In some cases a certain amount of sphincter action seems to have been left, retention of urine being possible for short periods, even for as long as two hours in a case recorded by Sir Spencer Wells. Turning to treatment, Dr. Haultain advises that when the exfoliating sac protrudes from the urethra a catheter should be passed, so as to empty the bladder slowly, and diagnose the condition from inversion of the bladder. The sac is then removed and the bladder washed out with a strong antiseptic solution, repeated every four hours till the temperature falls below 101°, after which the washing is to be continued at more lengthened intervals till the lotion returns pure. Constant drainage of the bladder is necessary, should there be the slightest tendency to retention of urine.—*Brit. Med. Jour.*, May 10, 1890.

Senator on Chronic Bright's Disease.—Among the causes of the disease there was, first, acute nephritis, which became transformed into chronic nephritis more frequently than was generally believed. Other causes were chill, syphilis, malaria, abuse of alcohol or tobacco, lead, and other forms of metallic poisoning, chronic pyelitis, and particularly lithiasis. Among the rarer causes were diabetes, pregnancy, heredity, climate, etc. As to syphilis the author deprecated thorough-going mercurial treatment. Local bleeding had no particular effect even in acute nephritis, as the kidneys, owing to their position, were not very accessible to direct influence, and the reflex effects were too feeble to be useful. As regards medicines, stimulants were to be avoided, and astringents, which theoretically should diminish

albuminuria, had not the desired effect. Experiments with benzoic acid, arsenic, ichthyol, and other remedies, had also failed; the same might be said of iron preparations, which had been given for the anæmia. Parenchymatous nephritis might come to a standstill at any stage, and disappear, leaving more or less organic change. The author had seen recovery take place even after the disease had lasted two years, and Johnson even after three years. As regards diet, albuminoid substances should be avoided, and food ought to consist of fat and carbon hydrates. This should be continued for several weeks, or even months; the patient should be well nourished, but the food should be such that the kidneys were freed from albumen as much as possible. According to Voigt, 80 grammes of albumen, 30 grammes of fat, and 300 grammes of carbon hydrates, had to be conveyed to the organism to keep up the equilibrium; the proportion of the albuminoids to that of the carbo-hydrates ought to be 1 to 4. But less than a half of the mentioned quantity of albumen would suffice: 50 grammes of albumen—equivalent to about 2 litres of cow's milk, or to from 8 to 10 eggs, or to 250 grammes of meat—was the lowest quantity required by the organism; this need not be exceeded if food free from nitrogen was taken in sufficient quantity. Many who were against the limitation of albuminoid food emphasized the necessity of giving strong food, which should ameliorate the condition of the blood. This gain of strength, however, said the author, could be obtained in another way, for instance, by the introduction of fat. The diet should be one by which the general condition of the patient was improved, and the affected kidneys were freed as much as possible, and this was a diet which contained little albumen, very much fat and carbo-hydrates. The majority of practitioners were in favor of milk diet, and in most cases about 2 litres of milk were given daily. The author was no partisan of the milk cure, but he never entirely abandoned the use of milk, as it contained no irritating substances, and it had also had a diuretic effect owing to the water it contained. Disturbances of digestion seldom formed a contra-indication; on the contrary, they were frequently improved by the treatment. In many cases butter-milk, and also koumiss or kefi, could be taken. The drink was also of great importance, as it not only satisfied thirst, but also had a diuretic effect. Brandy, strong wines, and beer, were very injurious. The wine of fruits was recommended, as it increased diuresis owing to the organic acids it contained. Besides food the activity of the muscles played a great part, as albuminuria was augmented by violent exertion. Moderate motion was therefore recommended. Fresh air was very useful, and the patients did well even to lie in the open air. Baths and *frottement* were of some utility, as there was some relation between the skin and the kidneys. Alkaline muriatic waters, the various teas, the acetate and tartrate of potassium, etc., had a diuretic effect, and this was also true of digitalis, squills, and strophanthus, by augmenting the activity of the heart. Caffein was contra-indicated, as it also affected the nervous system. Acid diuretics were, of course, contra-indicated. A similar treatment was also indicated in the case of atrophic kidney, in which iodide of potassium was useful, as it partly diminished the arterio-sclerosis which was amost invariably present. Strong cigars should not be smoked. Change of climate was useful, and patients ought to go Egypt, Lapland, India, etc.

In the discussion following this paper von Ziemssen said that in parenchymatous nephritis, in the treatment of albuminuria, pharmaceutical preparations should be used only with precaution, otherwise the digestion might be much disturbed. Astringents were useless; iodide of potassium was of some use, and in some cases ergot was successful. During exacerbations of albuminuria, and particularly if there was hæmaturia, the patients should be kept in bed. Bartele affirmed that after several years' confinement to bed, combined with the use of diaphoretics, he had seen well-developed albuminuria perfectly cured. Of diaphoretics, hot air and steam baths were chiefly indicated, especially the former. Pilocarpine was beneficial, particularly in dropsy of long standing. Digitalis, squills, acetate of potassium, and the preparations of antimony were also useful. Caffein and theobromin were useful diuretics, and did not increase blood-pressure. Calomel had no effect at all in renal dropsy. With regard to mechanical treatment, von Ziemssen introduced capillary tubes into the asepticized skin, fixed them with salicylate wool, and allowed them to re-

main *in situ* for twelve hours. In the case of interstitial nephritis, the various causes, such as alcoholic and metallic poisoning, gout, and syphilis, furnished particular indications. In excessive blood pressure bleeding was useful. In cardiac excitement, ice-bags and morphine were useful; and morphine and ice-pills were beneficial in vomiting. Uræmia was best prevented by digitalis and stimulants (camphor, alcohol). During the attack these drugs could be given by the rectum. In desperate cases, arterial bleeding and transfusion could be resorted to. In fibroid liver mineral waters were not good. A sojourn in southern regions was of benefit.

Ewald said that when milk was refused he used peptonized milk with great advantage. Iodide of potassium, to be of use, should be given in large doses. Prïbram remarked that in acute nephritis he observed strikingly good results from tannic acid; in chronic cases it was useful. Water containing carbonic acid should not be given in atrophic kidney, as hemorrhage might be caused.—*Brit. Med. Jour.*, May 17, 1890.

Tuffier on the Action of Aseptic Urine on the Tissues.—From injection of aseptic urine into the prevesical cellular tissue the author obtained neither inflammation nor suppuration. From injection of urine containing large amounts of chlorhydrate of ammonium identical results were obtained. By substituting the sulphhydrate of the same base he obtained a simple induration of a dark color.

The author concludes that the common effects noticed in extravasation of urine are due to the presence of special pathogenic agents.—*La Presse Méd. Belge*, April 20, 1890.

Albarran on Death Produced by Vesical Endoscopy.—A man had slight hematuria, thought to be dependant on a vesical tumor. The endoscope revealed no vesical lesion and a further examination detected an enlarged kidney, showing the hemorrhage to be probably of renal origin.

The patient died in forty-eight hours of acute urinary symptoms, and the autopsy showed an enlarged kidney, while the urine contained pyogenic bacteria. The only possible contagion was the endoscope, which, by the customary means, was evidently imperfectly disinfected.

The only sure way to sterilize the instrument is by heating it to 150° C., which precaution was not taken.—*Le Courrier Méd.*, April 26, 1890.

Schimmelbusch on a New Disease of the Mammary Glands.—The glands were large, but showed nothing special externally. On palpation the feeling was experienced of grasping a bag filled with smaller or larger stones. The glands were converted into hardish lumps, varying in size from a bean to a hazel nut. The overlying skin was fairly movable, and the individual nodules were also. The subjective symptoms were very slight, and limited to dragging pains, especially after exertion. Both breasts were generally affected. Of three cases observed by v. Bergmann, the first was a young lady, the second a powerful woman of thirty-three, the third a woman of fifty-four. The latter had felt the lumps in her breasts for eighteen years. Later, hard and painful tumors developed in both breasts, which were extirpated, and the newer growths proved to be carcinoma. The nodules in the left breast were cystic degeneration of glandular tissue. The only treatment was amputation. Lauenstein found in the case observed by himself that a dark, characteristic, green fluid could be pressed from the nipples. v. Bergmann remarked that the growth did not in any way implicate the interstitial tissue, but the glands only.—*Med. Press*, May 21, 1890.

Tripier (R.) on the Existence of a Tubercular Endocarditis.—In the body of a boy of fourteen, dying of general miliary tuberculosis, the author found, on the upper surface of the mitral valve, granular vegetations of recent formation and near by but on its under surface, between the insertion of two tendons, a small but characteristic tubercular nodule. This unique site of tubercular infection, together with those cases where various tubercular lesions have been found in veins and lymphatics, and with those cases where tubercular bacilli have been found in the blood, clearly demonstrate the mode of dissemination of tuberculosis by the circulation. Microscopic examination of these growths showed them to be of a tubercular nature.

The author has seen similar valvular lesions with caseous-tubercular and cavernous disease of the lungs, and concludes from these and other premises that the classical theory of the antagonism between heart disease and pulmonary phthisis is no

longer tenable.—*L'Union Méd.*, May 24, 1890.

Nicholson (W. P.) on a Deceptive Lipoma.—A man presented a pear-shaped tumor beginning at the extreme upper part of the scrotum on the left side, and hanging from its pedicle-like base, so as to resemble a divided scrotum. The history was vague, being traced to an injury twelve years before, with a gradual increase until a few months since, when it grew much more rapidly, so as to cause trouble by its weight. It appeared clearly to fluctuate, and was apparently translucent. I thought there was some solid matter, and it was unmistakably cystic. In cutting down as carefully as possible on the sack in order to prevent the escape of the fluid, I was much surprised to see a piece of fat come out of the wound, and then only was a correct diagnosis made, and a fatty tumor found, extending from the external abdominal ring to the ischio-rectal fossa, and so adherent as to require a long and careful dissection to remove it.—*Practice*, April 20, 1890.

Glénard (F.) on Exploration of the Liver in Diabetes.—The author claims that in 60 per cent. of cases of diabetes there is a manifest change in the liver, principally in the right lobe. The density of the liver is increased in a third and its sensitiveness increased in a quarter of the cases. An augmentation of volume is the most constant change, and this hypertrophy is indolent and indurated.

The author considers the process a sort of constant evolution. It is not to be distinguished from the change sometimes seen in alcoholism and lithiasis. According to the author, there frequently exists an alcoholic diabetes in which is found a steatosis or an alcoholic hepatitis, aborted or arrested in its evolution.—*Gaz. Hebd. des Sci. Méd. de Montpellier*, May 3, 1890.

Frequency of Cancer in Normandy.—According to a foreign contemporary, Arnaudet, of Cormeilles in Normandy, has been making investigations, the results of which show that the deaths from cancer in that province varied between 5.69 and 10.47 per cent. during the last six years or a mean of 8.8 per cent. This compares very unfavorably with the death rates in other towns of France. For example, in Paris it is 4.16; in Rouen, 3.8; in Havre, 2.4; in Rheims, 3.3 per cent. respectively. He attributes the high mortality to several causes, among which may be mentioned the badness of the well water, which is used for all domestic purposes, and in the manufacture of cider; then the over-crowding in the houses, by which several cases of cancer may be met with under the same roof. By reason of this it is possible to imagine that the morbid germ is preserved indefinitely upon the walls, interstices of the flooring, and other places. This would explain more satisfactorily than the theory of heredity the series of cases of cancer occuring in the same family. Arnaudet believes that cancer depends upon some local cause external to the body, and that the great predominance of cases of cancer of the intestinal tract over tumors of other situations points to the importance of diet as an element in the causation of the disease.—*Med. Press*, May 21, 1890.

REPORT ON OBSTETRICS AND DISEASES OF CHILDREN.

BY ELIZABETH STOW BROWN.

Croom (J. H.) on Retroversion and Retroflexion of Gravid Uterus.—In the pathology of pregnancy, uterine displacements play a very important part, and none more so than backward displacement. This form of displacement in a minor degree, the author believes to be by no means infrequent. Some years ago, he had occasion to inquire into the statistics, and found that out of fifty cases in which early pregnancy was diagnosed, in ten there was distinct backward displacement. But if gravid retroversion be comparatively rare, at all events in its pronounced form, it is certain that gravid retroflexion is still rarer, and that complete incarceration of the advanced gravid uterus is one of the least common accidents during pregnancy.

The writer relates the history of a well-marked case which proved fatal. He thus has had the opportunity to observe some interesting anatomical and clinical facts. The patient presented herself at the hospital with a note from her former medical attendant, stating that she was suffering from an ovarian tumor. She was unable to stand or walk. Her age was forty-three, she had had nine children and several miscarriages. She had missed three menstrual periods, and believed herself pregnant, though dur-

ing all the period of suppression there had been every day or two a little discharge of blood. Examination showed an even, smooth, tender tumor extending midway between the umbilicus and ensiform cartilage. *Per vaginam*, a large, irregular doughy mass was felt behind the posterior fornix vaginæ. Nothing of the nature of a cervix could be recognized. It was just possible higher up behind the symphysis to feel a thin, fibrous soft rim, which was supposed to be the anterior tip of the cervix. Passage of the catheter threw no further light on the case. There was a slight vaginal pulse, but no ballottement. Later, during the absence of the physicians, a nurse passed the catheter and drew off 116 oz. of urine, of claret color, ammoniacal, and which under the microscope showed pus and blood. The following day the patient died. On dissection the tumor was found to be the bladder containing urine and blood-clots, and lying beneath it the retroflexed incarcerated gravid uterus. The parts were removed, frozen, and sections cut, fine illustrations of which accompany the article.

The difficulty of diagnosis is by no means infrequent in cases of gravid retroversion of long standing, for in this case it is obvious that the bladder had been distended for at least a month. The characteristic symptom of gravid retroversion, urinary trouble, had set in about the usual time, the end of the third month.

A similar case to Dr. Croom's has been reported by Moldenhauer (*Archiv für Gyn.* vol. I).—*Edin. Med. Jour.*, April, 1890.

Dickinson (Robert L.) on the Time-Element in Saving the Perineum.—Slow stretching of the vulvar orifice seems to the author the most important consideration in the delivery of the head. Two propositions may be stated:

1. The more slowly and evenly the head is delivered, the less the chance of injury.

2. If twenty to thirty minutes are insured for the distension, rupture will rarely occur.

Some rigid, œdematous, or wet-paper vulvæ no care can save; some india-rubber perineums no speed can tear; but in ordinary practice the rule will be found of working utility.

The methods of delay are two: with [illegible]rm, and with restraint by manual

Experiments on the cadaver have shown that a muscle slowly stretched will sustain a much greater weight than one rapidly stretched. The order of giving way in tissues is: 1, adipose tissue; 2, fascia; 3, muscle; 4, skin.

Microscopical examination of the perineal structures of fat women, showed fat between the muscular fibres, and fatty degeneration also. Adipose tissue is frequently found in undue quantity in the perineum in strong young women when the only other accumulation is in the abdominal wall and the buttocks. The skin of persons between eighteen and twenty was twice as yielding as that of individuals between thirty and thirty-five.

When a double layer is distended, the inner surface gives way first.

The extent of the thinning of the pelvic floor in an important fact bearing on the speed question. The author has measured it, by passing in a thin lead plate between the head and the pelvic floor, and then driving a flamed needle through the tissues wherever it was desired to ascertain their thickness. The perineal body usually averages an inch and a quarter to an inch and a half in thickness after involution. When distended fully by the head, it is a little more than a sixteenth of an inch thick.

One hundred and forty-seven cases were timed. They were from private practice and hospital records. A large number of the patients were delivered by internes. The forceps cases were relatively numerous, because the time could be kept accurately, and the head extracted very gradually.

An accompanying table classifies these cases under appropriate heads. The author's conclusions have already been given in THE ANALECTIC AND EPITOME, p. 176.—*N. Y. Med. Jour.*, April, 5, 1890.

Booker (Wm. D.) on some of the Bacteria found in the Fæces of Infants Afflicted with Summer Diarrhœa.—These studies were commenced in the summer of 1886 with the view of learning:

1. The species of bacteria existing in the diarrhœal fæces of infants; the difference between these bacteria and those found in the healthy fæces of infants; what, if any, species of bacteria appear constantly in the diarrhœal fæces; the difference in the bacterial vegetation of the fæces of different forms of summer diarrhœa and in

mild and serious cases; the predominating form of bacteria in each case.

2. The biological and pathogenic properties of the bacteria isolated.

The author reviews the work of European pathologists in this line. Lesage in 1887 separated from the fæces of infants afflicted with green diarrhœa a bacillus to which he attaches considerable importance. He distinguishes two forms of green diarrhœa,—bilious and infectious. In the bilious diarrhœa the green color depends upon an over-abundance of bile coloring matter. It appears ordinarily between the fourth and twenty-fifth day, and is without further phenomena of disease. In the infectious form of green diarrhœa the stools contain only a small quantity of bile ingredients and are neutral or weakly acid. The green color is produced by a definite bacillus contained in the intestinal contents and stools of children affected with this form of diarrhœa. The bacillus is found in large quantity in the upper two-thirds of the small intestine, more sparsely and in long threads in the large intestine and stools. It is a rounded-end bacillus, 2—3 μ long, and 1 μ wide, and grows by division and spore formation. The latter has only been observed outside of the body in gelatin at 20°—22° C. The most conspicuous property of the bacillus is the production of a green coloring matter, soluble in water, becoming a darker green when exposed to air. This green color is produced in cultures on different nutritive media, and in gelatin it diffuses through the whole tube.

The children from whom Dr. Booker took the fæces for examination were chosen from 2,000 children sent to "The Thomas Wilson Sanitarium" in the summer of 1888, affected with summer diarrhœa, with special reference to the severer forms of diarrhœa.

Nineteen varieties of bacteria were isolated, all of which belonged to the bacilli.

The bacteria were obtained by introducing a sterilized glass tube into the anus and inserting through this a smaller and longer tube into the rectum. A discharge from the intestine occurs in a short time, filling the inner tube, which is first withdrawn and emptied immediately into a sterilized test-tube containing bouillon. Tables accompany the record of the observations. By reference to these, showing the distribution of the bacteria in the different cases, it is seen that, with the exception of bacterium lactis aërogenes and bacterium coli commune, the two constant or obligatory milk-fæces bacteria, no species of bacteria appear with much constancy, taking the cases as a whole. The frequent occurence of the proteus group, putrefactive bacteria, in the most serious cases of summer diarrhœa, in which toxic symptoms are more or less prominent, the author considers cannot be without significance.

No variety of bacteria appeared to be especially associated with the cases of catarrhal enteritis and dysentery. The author also shows that the inconstant bacteria not only vary in different cases, but also in different summers.

No chromogenic bacteria were isolated. Esmarch tubes, made from a large number of green stools, developed no green colonies.—*Archives of Pediatrics*, February and March, 1890.

Mittendorf (W. F.) on the Successful Removal of an Anterior Encephalocele.—Among the tumors of the head connected with the cranial cavity encephaloceles appear to be the most frequent, and yet they are quite rare, especially the anterior and lateral ones. These tumors are, with very few exceptions, congenital malformations and vary considerably in regard to size, location, and contents. The prognosis in all cases is very grave; the sac becomes more and more distended until it bursts; or sloughing of it will lead to a rupture and cause the death of the patient. In an encephalocele, if it has a small pedicle, sacculation and separation from the cranial cavity may take place, in which case the growth of the prolapse is arrested, and even if rupture should occur, it is not necessarily fatal. If death does not occur, there is, however, great danger that the patient will become more or less idiotic or paralytic.

The history of the case of anterior encephalocele reported, was that at the time of birth the child was found to have a swelling of the thickness of an ordinary lead pencil, extending along the left side of the nose and covering the left eye to a great extent. As soon as the baby was bathed and commenced to cry, the tumor began to enlarge and had grown so rapidly that on the fourth day it had the size of a pigeon's egg, and as soon as touched, or rather as soon as the child began to cry, it would become tense and swell considerably

The child was placed under chloroform, and on examination it was found that there was no connection whatever of the growth to the eye, nose, or tear-sac. It proved to have started from the median line of the forehead, between the eyebrows and apparently from the lower portion of the frontal bone. When the child was six days old the operation for removal was performed. The pedicle was ligatured with catgut, the tumor cut off by scalpel. The surrounding integument was dissected up so that it could be drawn over the stump.

The growth was located at the root of the nose, and had apparently left the skull between the cribiform plate of the ethmoid and the frontal bone, and appeared anteriorly between the frontal and nasal bone.

The child recovered from the operation perfectly. There is only a very slight scar, and the mental faculties do not appear to be disturbed in the least.—*Med. Rec.*, April 5, 1890.

REPORT ON THE DISEASES OF WOMEN

BY J. S. HAWLEY, M.D.

Coe (H. C.) on the Ultimate Results of Laparotomy for the Removal of Diseased Appendages.—By this is to be understood not the immediate results of the operation as to death or recovery, but as to relief of the symptoms which called for operation. These may be considered under the two heads of (1) Psychical results and (2) Physical results.

Under the first should be included not alone the transient "psychoses," to which attention has recently been directed as sequelæ of gyncæological operations, minor as well as major, but actual insanity. In a recent conversation with a prominent alienist, he stated his belief that most of the cases of insanity reported as directly due to the removal of the ovaries were open to suspicion, because a careful study of the patient's history would generally show that her mind was already so affected before the operation that she would probably have become insane even if it had not been performed. On the other hand, a gentleman connected with a large asylum stated, in a paper read by him not long since, that at least ten per cent. of the women whose tubes and ovaries were extirpated became insane in consequence. Careful observers do hold that there is a direct relation between the operation and the subsequent mental aberration which sometimes occurs. We ought under this head to consider the question of the "unsexing" of women by the operation, one which figured in a recent medico-legal case. We should settle this matter definitely so far as we are concerned. The physical results of laparotomy for removal of the adnexa may be general or local. Under the former are included the various neuroses which persist for years after the operation, circulatory abnormalities, such as true cerebral hyperæmia and various visceral disturbances, especially intestinal troubles, due to adhesions.

The persistent pelvic pain, congestion of the uterus (with or without a pseudo-menstruation), vesical and intestinal disturbances, which in a certain proportion of the cases are noted for years after removal of the tubes and ovaries, are directly due to intra-pelvic indurations or adhesions, which may have existed before the operation, or may be the result of localized peritonitis following it. If adhesions existed before the operation and are separated at the time, they, the intestinal especially, are very apt to reform. Small indurations around the stumps, or in the broad ligaments, are sufficient in themselves to cause constant severe pains, both local and reflex, and to induce a more or less permanent pelvic congestion. Even when ventro-fixation of the uterus is practised, one cannot be sure that the organ will undergo post-climacteric atrophy. Intestinal adhesions are of common occurrence, indeed, their absence is a matter of surprise when the fact is considered that the coils of gut must always lie in direct contact either with the stumps alone or (in complicated cases) with large, raw surfaces in Douglas' pouch and on the posterior aspect of the uterus and broad ligaments. Such adhesions, even when slight, may give rise to severe and irremediable colicky pains; when more extensive, the patient is in constant danger of intestinal obstruction. When for any reason the adhesions around the uterus and adnexa are separated without removal of the latter, they unquestionably reform, either at the old, or at new sites. When diseased adnexa —a pyosalpinx, abscess, or adherent cyst—

are emptied and fastened in an unnatural position, as in the abdominal wound, even if the intestines do not become adherent to it, undue traction is made upon the pelvic organs (and especially upon the neck of the bladder), thus giving rise to permanent distressing symptoms. Rigid antisepsis, absolute hæmostasis, cauterization of the stumps, and even of all new surfaces, the routine use of intra-peritoneal irrigation, and the removal of the water by siphoning alone, with the absolute interdiction of sponging, careful arrangement of the intestines and peritoneum before closing the cavity, early removal of the drainage-tube—all these precautions have been adopted, and yet intra-pelvic adhesions have formed, and that, too, in perfectly uncomplicated cases, in which the pelvis was absolutely free from adhesions when explored at the time of the operation. It seems to be practically impossible to predict that localized peritonitis may not develop in any given case, however favorable it may be.

The author then reports the histories of eight cases in which removal of the adnexa failed to relieve the former symptoms, and states that he has often demonstrated both in clinic and dead-house to his own satisfaction the fact that recovery from operations is not at all synonymous with cure.—*Med. Record*, April 19, 1890.

Goodell (Wm.) on the Danger of Syphilitic Infection by the Gynæcologist.—After citing a number of circumstances under which gynæcologists have acquired the disease from patients by pricking the finger during the operation, or inoculating a wound, or abrasion of the hand during his treatment of a syphilitic patient, the author concludes as follows:

"The knowledge of these facts has made me keenly alive to the danger which physicians in general, and gynæcologist especially, incur in the examination and in the delivery of women. It has also made me very careful to see that all my everyday instruments are kept scrupulously clean, for there is no doubt that careless physicians have unwittingly inoculated their patients by their instruments, and especially by the speculum.

Why physicians who contract this disease in the legitimate exercise of their duties should, as a rule, suffer more than those who pay the penalty of their immorality, I can explain only in one way: In the former, the sore is ectopic, and, by not being on its usual site, is not recognized early enough to be controlled by local and constitutional treatment. In the immoral the chancre usually appears on the genital organs, where it is anxiously looked for, and where its identity is unmistakable."—*Annals of Gyn. and Pædiat.*, March, 1890.

Frank on Total Extirpation of the Uterus for Non-Cancerous Conditions.—The author considered the subject of removal of the non-cancerous uterus a very important one for discussion, the operation being one of the most beneficent in gynæcology for uterine diseases which have refused to yield to all other means of treatment. The operation is one which is without danger if the uterus is enucleated from the peritonæum. The author has performed it twenty-five times without a death. In all cases benefit has resulted from the operation, inflammatory processes, ovarian neuralgia, and other pelvic troubles disappearing. In two cases removal of the ovaries had failed to relieve hysterical troubles, one of the cases showing the most violent hystero-epileptic attacks. Both cases were completely cured after the performance of hysterectomy. These two cases convinced the author that if the ovaries are to be removed the uterus should be removed at the same time.—Translation in *Annals of Gyn. and Pædiat.*, March, 1890.

Phillips on the Complication of Pregnancy by Fibromata.—The following are the conclusions of the paper:

1. Fibromata may cause abortion, a tumor in the uterine wall being obnoxious to its symmetrical development.

2. They may cause local peritonitis with adhesions to intestines, etc., and the pain may be so severe that it may be necessary to arrest the pregnancy.

3. The pelvic canal may be so obstructed that Porro's operation or Cæsarean section may be required.

4. They may cause an abnormal presentation, and the result may be the death of the fœtus.

5. The placenta may adhere to the tumor and require forcible removal. There may be placenta prævia.

6. They may cause ineffectual uterine contractions, and retard involution.

7. They may soften and disintegrate before parturition, this being followed by peritonitis. There may be torsion of the

pedicle and consequent gangrene.—A. F. C., Translation in *Annals of Gyn. and Pædiat.*, March, 1890.

Cleveland (Clement) on Laparo-Vaginal Hysterectomy.—The history of a case of carcinoma uteri is reported, in which an attempt to remove the uterus by the vagina was unsuccessful on account of the small size of that canal, making it impossible to apply either forceps or ligatures to the broad ligments from below. After the cervix had been separated from its vaginal attachments the abdomen was opened and the blades of strong forceps, passed from below, were adjusted by the fingers passed into the abdomen through the incision in its wall. The forceps could be perfectly adjusted in this manner so as to secure the vessels of the broad ligament, which were then divided close to the body of the uterus from above, and the organ removed through the incision as it was too large to be delivered *per vaginam*. Recovery was retarded by the existence of a small vesico vaginal fistula resulting from a wound of the bladder made during the first steps of the operation, and by a mural abscess. The author has formulated the rule by which he will be guided in the future as follows:

"To do vaginal hysterectomy in cases where it can be easily and quickly done; but in cases where the vagina is small and the uterus difficult to draw down, I would first make a short abdominal incision, low down in the median line, and a small opening into the peritoneal cavity, just large enough to admit the tip of the index finger. This opening in the peritoneum I would then temporarily close by a small clamp, and cover the wound with an antiseptic pad. I would then proceed as for vaginal hysterectomy. When it came to securing the broad ligaments, I would apply the forceps as in the case related, guiding their adjustment by the index finger of the left hand passed through the abdominal opening. This method admits of thorough irrigation from above. If the uterus is found too large to be removed per vaginam, the abdominal incision can be at once enlarged and the uterus removed from above."—*Am. Jour. Obstet.*, May, 1890.

Sandberg (Karl) on the Time when an Ovarian Tumor Calls for Interference.—When all things are taken into consideration, the author believes that it should be agreed that it is bad practice to wait "until the patient's health is affected or her life threatened"; "until she is failing in strength and becoming emaciated depressed, or nervous"; "until she is seriously distressed and her health or activity impaired"; "until sharp abdominal pains lead to the suspicion of localized peritonitis and adhesions"; "until the belly is distended and the woman has become thin and her health has begun to fail"; "until the tumor has reached the umbilicus"; "until it is beginning in any way, physically or mentally, to do harm, or until the woman has become accustomed to the confinement of a sick-room and has lost flesh."

None of these conditions is required for any other operation, and they are only reminiscences of the time when ovariotomy was considered preferable only to immediate death. The sooner we throw them overboard the better. An ovarian tumor always calls for interference, and it calls loud enough to make additional indications unnecessary. — *Am. Jour. Obstet.*, May, 1890.

Busey (Samuel C.) on Genital Hemorrhage in the Newly Born.—The author reports the history of the second case in his experience of this condition occurring in a child born in an asphyxiated condition, and with the funis tightly wound about its neck. The uterine contractions at the close of labor were very severe, and were not controlled by the administration of chloroform, to the point of profound narcosis, and the head of the child was driven through the vaginal opening, lacerating the perinæum extensively. The child measured twenty-one inches in length and weighed six and one half pounds.

Upon removing the napkin at the time stated, the nurse discovered in the vulva a clot of blood which she represented was as large as a hazelnut. Upon its removal the blood continued to flow, and an hour later, another clot occupied the locality. It was also removed, and the blood continued to ooze slowly but continuously. The nurse was directed to drip into the vulva a solution of alum from a small pledget of absorbent cotton, and then to place the pledget in the vulva and press it gently towards the hymen, and to give the child whiskey in doses of four drops every two hours. At the afternoon visit there was no abatement of the hemorrhage, and the

almost inaudible whine of the pulseless infant demanded some more decisive treatment or death was inevitable. In addition to what was being done, two drops of the fluid extract of hydrastis canadensis were given in water every four hours. It was continued until the morning of the seventh day—thirty-six hours—when it was discontinued, the hemorrhage having ceased. During the following night there was slight recurrence of hemorrhage, and the hydrastis was resumed and continued for several days. There was no sign of bleeding after the morning of the ninth day, and during the afternoon of that day the radial pulse could be felt for the first time since the birth of the child. With careful nursing and proper feeding it continued to improve.

The prognosis is favorable, and in cases of such clinical insignificance treatment would seem to be nugatory. In fact, when occurring in robust, healthy infants, it would appear wisest to let it run its course to spontaneous cessation. It may, indeed, be a salutary hemorrhage, relieving a localized congestion of the pelvic viscera; and yet the author is convinced that the fluid extract of hydrastis did have a beneficial effect in the case.—*Amer. Jour. Obstet.*, May, 1890.

Engelmann (Geo. J.) on Operation in the Early Stages of Extra-Uterine Gestation.—In presenting a specimen removed *post-mortem* from a woman who had given no symptoms of pelvic trouble until the day of her death, when she first suffered from cramping pains in the abdomen, and soon went into collapse and died, the author comments as follows:

"I have been quoted as favoring electricity, at least in the hands of the general practitioner, in the very early period of extra-uterine gestation, and such, indeed, has been my repeatedly expressed opinion.

"Increased experience has caused me to waver, and a case recently recorded has appeared to me so convincing an argument in favor of *immediate operation* at *whatever period* extra-uterine pregnancy may be detected, that I am now an earnest advocate of surgical interference in all such cases, although I would still urge electricity to be used until the diagnosis is fairly established, or until dangerous symptoms appear, when the abdomen should, of course, be opened, whether or not the diagnosis be assured. . . . While so early a rupture may be unusual, it is enough to know that it does occur, and hence it is self-evident. I may say, any other but surgical treatment in a case of ectopic gestation endangers the life of the patient, as each day of delay must appear to be the loss of a golden opportunity, unless primary rupture has already taken place and pregnancy is well advanced; then we may deliberate as to the proper course to pursue.

"It is on the evidence afforded by the history of this case, and the specimen presented, that I have abandoned the teaching that electricity should be tested in the early stages of extra-uterine fœtation, and would now urge immediate operation."

The autopsy showed the uterus to be slightly enlarged, the cavity, however, being of normal length, the tubes perfectly healthy and free from any adhesions, but with unusually thin walls. The right tube showed an enlargement at about 2½ *cm* from the uterine extremity, measuring 4½ *cm* by 3½ *cm*, with a small opening from which a blood clot protruded. The fœtus was not found, but the amnion and chorion were recognized by the microscope as constituting the mass in the sac. The non-adherent condition of the adnexa showed the ease with which the sac could have been removed by operation.

The patient had not missed a menstrual period, but had flowed for five or six days longer than usual at the last menstruation. —*Annals of Gyn. and Pæd.*, May, 1890.

Pratt (H. D. V.) on a Case of Retro-Uterine Tubal Pregnancy, Causing Obstruction of the Bowels.—The diagnosis was made when the pregnancy had advanced to the third month. In addition to the usual symptoms, there was complete obstruction of the bowels for a week. An opening was made in the sac from the vagina with the cautery knife, and the fœtus removed. The hemorrhage was profuse, but was controlled by a tampon, which was renewed several times before the sloughing placenta could be removed. The patient made a good recovery.—*Annals of Gyn. and Pædiat.*, May, 1890.

Macquibban (C. M.) on a Unique Case of Extra-Uterine Pregnancy.—Patient, aged forty-three, supposed to be in the fourth month of gestation, had been suffering for about three weeks with severe abdominal pain, etc. A tumor was found in the posterior *cul-de-sac* of the vagina,

and either hæmatocele or ectopic gestation diagnosticated. On opening the abdomen the cyst was found adherent to the posterior surface of the uterus, and independent of the Fallopian tubes. The abdominal incision was closer, and the cyst punctured *per vaginam*, and a well-formed fœtus of about four months' development was delivered. The placenta was not removed. The sac was drained through the vagina, and ultimate recovery was had.—*Br. Med. Jour.*, April 26, 1890.

Price (J.) on Three Cases of Ectopic Gestation. — Case I. — Patient, aged twenty-six; married for ten years; had borne two children, and had had three miscarriages during the eight years subsequent to the birth of the last child. Menstruation had been regular. Examination revealed trouble on the right side.

The right appendages were removed for a ruptured tubal pregnancy. Rupture at the fimbriated end of the tube. Abdomen full of clotted blood and debris. Irrigation and drainage.

Case II.—Patient; aged twenty-nine; married ten years; two children, last five years ago; saw her menses last in June, 1889; was supposed to have miscarried in August, and ever since has had irregular metrostaxis attended by attacks of intense abdominal pain. Had noticed a tumor growing in right side for several months. At time of operation was in fair general condition. Removal of seven months' fœtus lying transversely on the fundus of the uterus, the head in the right iliac fossa and the extremities to the left and above. The fœtus was below the omentum and bowel, which were universally adherent and encapsulated the fœtus. The rupture was an old one. There was no trace of placenta. Irrigation and drainage.

Case III.—Patient; aged twenty-two; married twelve years; three children, the last eight years ago. Since February 1st she has had irregular metrostaxis with recurring attacks of pain and collapse. Anæmia was profound. The ordinary symptoms were those of prolonged sepsis from pus in the pelvis. Removal of right appendages for ruptured tubal pregnancy. Placental debris, membranes, and fœtus were in the abdomen, which was filled with clotted blood. Irrigation and drainage.

1. *Diagnosis.* — First and third cases supposed to be pus. Second case extra-uterine pregnancy or fibroid.

2. Rupture of tube not necessary for fatal hemorrhage, *e. g.*, cases bleeding from open pavilion.

3. Ruptures into broad ligament. Hemorrhage limited by adhesions, etc., old and new.

4. Caused by old tubal disease, etc.

5. Hart & Carter's frozen sections do not necessarily prove all lingering cases to be between the folds of the broad ligament.

6. Condition of patients is no excuse for delay in operating.—*Annals of Gyn. and Pædiat.*, May, 1890.

The Treatment of Varices of the Vulva.—The practical importance of the extravasation of blood about the vulva becomes apparent when we consider the occurrence and course of hæmatomata of this region, varices, or the rupture of a vessel during labor. Not only may sudden acute hemorrhage bring the patient into a condition of collapse, but also thrombosis and embolism may result, with exceedingly serious consequences.

A recent case of pulmonary embolism following hæmatoma of the vulva, in which a dangerous pneumonia resulted, emphasizes these remarks. In the *Revue Médico-chirurgicale des Maladies des Femmes*, March 25, 1890, Batuaud writes upon varices of the vulva and their importance in obstetric practice, basing his remarks upon a recent thesis by Moussard, of Paris.

So far as diagnosis is concerned, there can be but little difficulty in recognizing this condition. The prognosis is favorable in ordinary cases, but depends upon the possibility of rupture and embolism. If they occur during pregnancy excessive exertion should be avoided—violent respiratory movements are especially injurious; and should rupture be threatened, pressure should be made by a T-bandage; when local irritation and discomfort are present, cocaine and starch-powder, or starch-water, will be found useful. When hemorrhage occurs, compression should be promptly made, either by a small *pincette* of some sort or by hæmostatic forceps if the point of rupture is discernible; if not, an antiseptic compress and T-bandage are indicated.

In cases of syncope after labor, depending upon severe hemorrhage from whatever cause, good results have followed the hypodermic injection of dilute solution of chloride of sodium (6 to 1000).

During labor the bladder and rectum should be promptly emptied to relieve pressure, the pelvis should be elevated, and precautions taken that the head is not born too soon, or with violence. Chloroform is found a most useful adjunct in modifying the forces of labor.

The forceps is occasionally indicated to restrain the head and control its exit.

Pressure may be made upon the varices during labor by the fingers of the obstetrician, or by an antiseptic pad should rupture threaten.—Editor. *Med. News*, May 24, 1890.

REPORT ON DISEASES OF THE SKIN.

BY CONDICT W. CUTLER, M.D.

Jackson (G. T.) on Seborrhœa.—Up to two years ago seborrhœa was considered a functional disease of the seborrhœal glands. Unna, however, claims that there is no such disease as seborrhœa. He teaches that the process is inflammatory from the start, and that the oil that fills the epithelial scales comes not from the sebaceous glands but from the sweat-glands. What we have called seborrhœa sicca he would have us call, for the present at least, seborrhœal eczema. He describes it as having three stages: First, the lowest grade of inflammation in which we have a simple desquamation of the upper layers of the skin; the condition that is commonly called pityriasis capitis. Secondly, a higher degree of inflammation in which we have a greater amount of scaling of the upper layers of the skin, and a heaping of them into more or less thick crusts; the condition we have described as the first variety of seborrhœa sicca. The third stage is one of more violent inflammation, in which the itching is pronounced, and there is redness of the skin; this corresponds to our seborrhœa with dermatitis. This third form he describes as met with on any portion of the body, and thus would make it equivalent to those forms of eczema we have always called squamous and orbicular.

One of the arguments given by Unna, to prove his theory of the production of the oily secretion that is found in the scales, by the coiled glands, is that there are too few sebaceous glands to keep the integument supplied with a sufficient amount of fat. Another argument is, that the palms and soles are well oiled, though there are no sebaceous glands in those parts.

The treatment of seborrhœa is simple, and far the most satisfactory remedy has been sulphur. After the removal of the crusts by means of any oil, or grease (this should be done the first thing whatever remedy is chosen), the sulphur is to be applied in the strength of a drachm to the ounce, either suspended in sweet-oil, cotcotton-seed oil, or vaseline. It should be rubbed into the scalp and the application repeated every night for one week. It is well to advise the patient to wrap his head up in a towel, or to wear a night-cap. This for the benefit of the housekeeper, who will thank you for saving the pillow-cases. After one week's use of the sulphur the head is to be washed with soap and water, and the oil, or salve, immediately reapplied. During the second week it will be sufficient to make the application every other night. Thus the treatment is to be continued, the number of applications being reduced until they are made but once a week. By this time the disease will be cured.

If there is any objection to the use of sulphur a good substitute will be found as follows:

℞	Hydrarg. ammon.	ʒ ss.
	" chlor. mitis.	ʒ iss.
	Vaselin.	ʒ i.

LASSAR'S TREATMENT.

Wash the head thoroughly for ten minutes with tar soap. Wash out the lather with plenty of warm water followed by cold water. Dry the hair and apply:

℞	Hydrarg. bichlor.	gr. x.
	Glycerini	
	Spirit vini rect.	ʒ ii.
	Aq. destil.	ʒ v.

M.

Follow this with

℞	Napthol.	gr. xv.
	Alcohol. absolut.	ʒ iv.

M.

Rub this in till the hair is dry, and then apply

℞	Acid. salicylic	gr. xxx.
	Tinct. benzoin.	ʒ i.
	Ol. ped. taur. vel.	
	Neats foot	ʒ iii.

M.

—*St. Louis Clinique*, April, 1890.

Huntley on Madura Foot.—The disease usually runs the following course: First, pain, associated with a boil or blister, the black particles being present before the blister bursts externally. In the beginning the sore is superficial. Following this we have implication of the surrounding skin, and the formation of fresh sinuses round the parent one. This may be named the first stage. In the second we have the tumor sending off branches in various directions among the tissues, finally, in the third stage, passing into and destroying the bones.

There is one thing very peculiar about those tumors or sores—viz., that while well known to be local affections, they simulate in physical characters malignant tumors more than benignant ones. You have a firm, hard lump among the tissues, irregular in shape, giving pain; to eye appearances quickly passing into the ulceration stage; the ulcers or openings never healing up; the early implication of the skin; and the tumor firmly attached, and moving with the surrounding tissues, which, in some manner, it supplants and destroys. There is the total absence of any capsule, and very little definement of its limits. Physically, it would lead us to suspect malignancy, but, on the other hand, the history, the absence of constitutional effects, and the knowledge that complete removal is not followed by a return of the growth have all along stamped it as belonging to the class of non-malignant tumors.

Treatment consists in complete excision of all the tumors and their sinuses.—*Glasgow Med. Jour.*, May, 1890.

Hildebrand on Multiple Cavernous Angeiomata.—Multiple cavernous tumors develop in the subcutaneous tissue. They have well-marked though thin connective-tissue capsules, from which processes go off into the tumors forming their mesh-work, which varies in amount in different tumors. The septa are furnished with blood-vessels. The meshes contained blood; some have phleboliths. No direct relation is found between the tumors and larger blood-vessels, but quite a large number of small arteries enter them. Some are found in relation with large subcutaneous veins. The vein runs alongside of the angeioma and gave off to it a small branch. In one case, opposite to its point of entrance, there was a vessel of the same size emerging from the tumor, which was an artery, so that the engeioma lay between an artery and a vein, being supplied with blood by the former. As the artery approached the tumor it widened out, and its outer wall became the capsule of the tumor and its inner wall the partition walls of the tumor.—*N. Y. Med. Jour.*, March 8, 1890.

Fournier on General Treatment of Syphilis.—Fournier advises withholding all drugs until sure that the chancre is a true initial lesion Once begun, the mercurial treatment is to be kept up continually for a number of years, with occasional interruptions of one to two months. This latter method will prevent tertiary accidents in from ninety to ninety-five per cent. of the cases. The proper length of time during which mercury is to be taken varies with the cases. Some patients never get well, are subject to constant relapses, and need to be treated all their lives. In most cases two years *at least* must be devoted to the administration of mercury; better, three or four years. After leaving off mercury, iodide of potassium should be administered, with alternating intervals of complete absence of medication. During the first year of iodide administration four courses are to be taken, during the second and third year three. His usual method of treatment is the following: On the appearance of secondary symptoms he prescribes five to ten centigrammes of the protiodide of mercury a day during six to eight or nine weeks. Then a pause of six weeks is made, and and another six weeks' course is taken. During the first year four courses are gone through with, during the second three, and during the third two, after which the potassium iodide is given, forty-five grains a day for six weeks, and then pauses as already indicated. In the meanwhile general hygiene and tonic treatment is not neglected.—*N. Y. Med. Jour.*, March 8, 1890.

Vander Horck (M. P.) on the Treatment of Lupus Vulgaris.—The scabs are first removed by dressings of olive oil and then the parts are washed daily with a solution of the bi-chloride (1-1000). A mask, consisting of 20 per cent. pyrogalic-acid vaseline ointment, spread on pieces of soft muslin, are made to fit the parts, and applied for four days at a time, alternating thereafter for a similar period with iodoform ointment. This treatment

is continued until it had been repeated five times, when the disease has almost entirely disappeared. If isolated spots of lupus infiltration remain, these spots are thoroughly cauterized every third day until they are all healed. — *North-Western Lancet*, May 15, 1890.

Ohmann Dumesnil on Factitious Urticaria.—Factitious urticaria is a form of urticaria or nettle rash which is of unusual occurrence. Like urticaria, it is characterized by outbreaks of wheals, but, in addition to this, if a blunt instrument, such as a tooth-pick, be drawn across the skin, a wheal immediately forms over the site of the irritation. In this manner letters may be traced which are elevated, of a whitish color having red borders. This will persist for some little time. The cause of such a condition is doubtless connected with trophic nerve irritability. It is claimed by some that the gouty habit has a certain influence upon the production of this peculiar condition.—*St. Louis Clinique*, April, 1890.

Ohmann Dumesnil on Suppurative Folliculitis.—Suppurative folliculitis attacking the hairs of the legs is quite a common affection. The lesions which are presented are almost identical with those of sycosis, viz., numerous pustules, each one pierced by a hair, redness and infiltration of the skin, tubercles, and small abscesses. Pain is a prominent factor. The trouble has a tendency to spread rapidly, as the small amount of itching present is relieved by the patient's scratching, and his nails transfer the pus to other localities, which are affected in consequence of this. The portions which are most commonly contaminated are the chest, the left axillary cavity, and the left arm, if it be the right leg which is affected, and vice versa. In the treatment of this trouble, simple measures will rapidly restore the parts to a normal state. Evacuation of all the pustules should be practised twice daily, and immediately after each evacuation campho-phenique should be liberally applied, not only over the affected surface, but a little beyond it, in order to prevent any further spread. This treatment will soon relieve the condition. After an apparent cure it is a good plan to wash the portions which were affected once daily with a 1-1000 solution of corrosive sublimate. This will act as a preventive of any relapse.—*St. Louis Clinique*, April, 1890.

Calwell on a Peculiar Affection of the Nails.—The disease consisted in an enormous hypertrophy of the papillæ of the bed of the nails, producing masses of hard, scaly, mortar-like material, which lifted up the nail, sometimes to a right angle with the axis of the finger, and caused it in many to break off short. It had commenced while the patient was undergoing a "crisis" at a hydropathic establishment. All four extremities were affected, but in all some nails escaped. There was great wasting of some muscles; less of others. Sensation was fair. There was tenderness in the course of some nerves, but no centric lesion was established. The patient had had attacks of eczema and periodical copious deposits of urates.—*Brit. Med. Jour.*, May 10, 1890.

Verruca Necrogenica.—Verruca necrogenica is probably but one form of tuberculosis verrucosa cutis. It is seen most frequently in dead-house attendants, medical students, and anatomists. The backs of the hands and fingers are most commonly affected, the palms more rarely, and the disease seldom occurs on the rest of the body. The most complete description of the disease was given in 1886 by Riehl and Paltauf in the *Vierteljahresschrift für Dermatologie und Syphilis*, and it is to them that we owe much that we know about the disease. A typical patch has a narrow erythematous border about it. Inside of this there is an area which is raised, and towards its inner part becomes more and more papillomatous or warty. The skin is crusted, and, if the patch is squeezed laterally, pus will be seen to ooze up between the papillæ in little drops. Rhagades run between the papillæ. The color of the patch is a dull red. Infiltration is well marked. In an old patch it will be seen that the central part has become flattened and changed into a sieve-like scar. The disease spreads at the periphery, while it heals in the centre. The shape of the patch may be circular, oval, or serpiginous, and it may attain to a size large enough to cover a good part of the back of the hand. The patch bears a strong resemblance to lupus verrucosus, but differs from it in not having any of the characteristic brownish tubercles of lupus, in showing no tendency to ulcerate or to return in the scar, and in occurring at the later period of life. That the disease is a localized tuberculosis of the skin is shown by finding the tubercle

bacillus in the lesion, by cases of general tuberculosis occurring in the subjects of the disease, and by the recent successful attempts at inoculation made by Brugger, of Würtzburg. The treatment of the disease is by destruction of the growth, either by cutting it out, by scraping it out, by the use of caustics, or by a combination of any two of these methods.—Editorial, *N. Y. Med. Jour.*, May 31, 1890.

Bourgeois on Treatment of Scabies with Petroleum. — Dr. Bourgeois believes that petroleum is the most efficacious antisporic, the cheapest, and easiest of control. All patients treated according to the following plan have been completely cured within three days :

The first day he orders, just before the patient retires, inunctions of petroleum over the whole surface of the body, except the head, rubbing more particularly the surfaces most affected. The shirt is then resumed and the patient put to bed. The next morning the greasy substance is washed off with warm water and white soap. The linen is changed, and the patient goes about his usual occupation. At night, before retiring, a new application of petroleum, as before, and the following morning the same procedure to remove the oil. Ordinarily, after the second day the itching is completely relieved ; but, as a measure of security, it is well to make a third application, after which the patient may be considered completely cured.—*Journal of Cutaneous and Genito-Urinary Diseases*, May, 1890.

SURGERY.

On the Surgery of the Vermiform Appendix.—At a meeting of the Practitioners' Society of New York held March 7, 1890, Dr. Wm. Bull introduced for discussion the question whether "excision of the appendix vermiformis is justifiable in cases of recurring appendicitis." He said that in the application of any surgical operation to the cure of disease we should consider the danger to life from the condition which it seeks to relieve, and contrast it with the risks to life from the operation. If the disease be threatening life, a dangerous operation is proper. If it merely interferes with the comfort or safety of the patient, why an operation of moderate risk can be recommended. A patient who has one attack of appendicitis is not a proper subject for operative treatment. Recovery is probable with simpler and safer methods of treatment. He has as much right to expect immunity from another attack as a recurrence, and in the latter event an equal chance of favorable or unfavorable result. The danger to life is trifling, and needs no protection from such an operation as removal of the appendix. But the subject of frequent recurrences, with the constant suspense and dread in the intervals of another attack, with the frequent interruptions to business, may properly undergo surgical treatment which is not attended with great risk. While he should not, in the light of present experience, encourage operations for one attack of appendicitis without urgent symptoms, he is unqualifiedly in favor of them when the attacks recur frequently. Is the operation easy and safe ? Morton speaks of it as a "comparatively trivial operation at a time and under conditions where prompt and permanent relief and recovery can almost invariably be secured." And Senn writes : "Excision of the appendix in cases of simple uncomplicated appendicitis is one of the easiest and safest of all intra-abdominal operations." On the other hand, in one of the cases operated upon by Mr. Noyes, the appendix and cæcum were buried in adhesions, and the dissection was complicated and tedious.

In a case under the care of Dr. J. C. Lester, of Brooklyn, operated upon by Dr. Bull last winter, the attacks had recurred with considerable regularity at intervals of three weeks for four months. They lasted only two or three days and were always accompanied with fever. The patient was a lady, sixty-three years old, and of good health, excepting this condition. A small ileo-cæcal tumor could be felt. On making an incision which opened the peritoneal cavity and also explored the iliac fossa, the condition was as described in Mr. Noyes' case. To dissect the appendix from the mass of plastic exudation would have been a prolonged operation, difficult and risky on account of the extensive raw surfaces which would be left behind in the peritoneal cavity. He closed the peritoneal wound, and left a drain in the wound outside the cavity. There has been a marked improvement in her condition. There is a constant purulent discharge from the tube, trifling in quantity, and any thing like a

repetition of the attack has occurred only when the tube was occluded or temporarily dispensed with. She and her family decline the risk of further operation. In another case, already reported, in which he did laparotomy, expecting to find an abscess, he met with a similar embedding of the appendix alone (the cæcum was free) in such a mass of exudation that he deemed it prudent not to attempt its excision.

In another patient, a boy of fourteen, who had experienced a number of attacks in one year, excision of the appendix was recommended by Dr. Bull, and done later by one of the most important and experienced surgeons in the city. The mass of fibrous exudation about the cæcum and appendix was so large that a stricture of the cæcum was diagnosticated and an anastomosis made between the lower end of the ileum and the ascending transverse colon. By the time the wound of this operation healed, the attacks recurred. A subsequent operation was done, and the appendix was found containing a small amount of mucopus and a concretion in the midst of the exudation. It was a very difficult performance, and by no means devoid of risk, but was fortunately followed by recovery and no return of symptoms. These are different conditions from those met with in the cases reported by Senn, and justify the conclusion that excision of the appendix is not to be considered an easy and safe operation. While it may, on technical grounds, be considered less dangerous than other intra-abdominal operations, we are liable to meet with complications, the management of which makes the procedure risky to the life of the patient—and it may be added that at present we know of no symptom or signs by means of which these complications may be detected. In the boy above mentioned the most careful palpation did not reveal the presence of such exudation as was discovered on dissection. In the presence of a distinct induration or tumor the operation must most certainly be considered dangerous, although when the appendix is free, or only lightly or recently adherent, the removal is a reasonably simple, safe procedure. The testimony of statistics we cannot yet give, as but few operations have been done. It is to be hoped that operators, in reporting cases, will ascertain whether hernia has followed the extensive incision of the abdominal wall. Dr. Bull had seen half a dozen cases of serious ventral hernia following operations on the appendix, the victims of which complained bitterly of their condition.

Dr. W. M. Polk said that in many respects the question of operating for appendicitis was in about the same stage as was that of operating for disease of uterine appendages several years ago. At first there was great fear about operating upon those cases complicated by adhesion, but now they were operated upon almost as freely as the uncomplicated cases, and with the most favorable results. It was true that in these cases one was operating in a region in which the vessels were much less important than he was likely to come in contact with in appendicitis, for while all knew that the appendix frequently lay close to Pouparts ligament, yet it not infrequently lies alongside the larger vessels, might even cross them and lie down in the pelvis, so that any effort at tearing up the adhesions except by careful dissection seemed to him, independently of the nature of the organ one was dealing with, to be attended by more risk than the same procedure addressed to the ovaries and tubes. If the tube and ovary were torn, there would merely be an escape of pus, which could easily be washed out and the diseased mass entirely removed. If one happened to tear the attachment of the stump to the uterus, the bleeding would be of little consequence and could be readily corrected, but if one tore the attachment of the vermiform appendix to the intestine, or tore the intestine itself, another operation would be added to the original one which required a good deal of time and skill. He thought, therefore, that a little greater conservatism was proper in dealing with cases of appendicitis than in dealing with cases of diseased tubes and ovaries.

Dr. W. H. Draper had seen a number of cases of recurring appendicitis in which recovery had taken place without resort to an operation. He could not recall a case of fatal peritonitis from appendicitis when there had been a previous attack—the fatal cases always recurring, in his experience, in persons who had had no other attack.

Dr. A. H. Smith recalled six cases of appendicitis with suppuration which had come under his observation, in three of which surgeons operated and all died, while the other three not operated upon recovered. Of the six, only one was a case of recurring appendicitis. It was

operated upon at the second attack, and pus was reached almost immediately upon division of the abdominal walls. The search for the appendix, however, was prolonged; the intestines protruded from the wound, and the patient never rallied from the ether, although in fairly good condition before the operation. In one of the other fatal cases the appendix was found and removed; in the other the abscess was opened, and no attempt was made to find the appendix. In one of the cases not operated upon the pus discharged into the bowel, and recovery took place; in the other two the pus made its way to the surface. He thought every recurrence of an appendicitis must result in a firmer barrier to resist rupture of the abscess into the peritoneum, if one had formed, rendering more likely its pointing externally or into the cæcum. In recurrent attacks it seemed that no pus formed, or else it was small in amount and escaped into the bowel and out with the fæces without detection. He would be loath indeed to sanction an operation in these cases as a mode of prophylaxis.

Dr. Geo. F. Shrady said that we must take into consideration that there are three conditions of appendicitis. One was single inflammation, which left no results, or only slight adhesions; another terminated in fibrinous effusions, more or less extensive; while the third terminated in abscess. With reference to the first condition, he had had a great deal to do with one case which had made a great impression on him. A physician had four distinct attacks of appendicitis, in all of which the question of operation arose. Dr. Shrady saw the patient in three of the attacks, all of which were well pronounced. The fourth occurred in Paris, where the patient was seen by a distinguished surgeon, who made a like diagnosis. There also the question of operation came up. Each attack was attended with all the usual severe symptoms which would appear to usher in the formation of an abscess; there was dulness, tenderness, more or less rigidity, and some œdema in the neighborhood of the cæcum. In each attack the advisability of operation was freely discussed. The patient was willing to take the risk, but in each instance the symptoms gradually disappeared, and he recovered. Dr. Shrady examined the appendix after death (from another cause) and found it to be perfectly sound. There was not the slightest appearance of any inflammation around it; it was not even thickened.—*Med. Record*, April 26, 1890.

According to Dr. S. G. Morton[1] the appendix is normally situated immediately under a point two inches distant from the anterior superior iliac spinous process, in a horizontal line drawn from this process toward the median line of the body. When the abscess cavity is reached, gas may be first discharged, then, when pus, which is always effusive, has been reached and sponged or washed away, the appendix is found, either lying free or attached to the cæcum or abscess wall. It is not always an easy matter to distinguish the appendix; on one occasion this organ and an epiploic appendage, each the same size and resembling each other in general appearance, were side by side, and both firmly glued to the cæcum. The anatomical relation will always differentiate the appendix.

Dr. Norman Bridge, of Chicago, gives the following as the cases in which surgical interference is demanded.[2]

1. Cases with rather protracted high temperature, and with distinct induration, which does not yield in forty-eight hours.

2. Cases of undoubted severe inflammation lasting several days, even though no particular induration can be made out (without appendicitis), and in acute localized peritonitis, having its origin at the appendix, and producing marked constitutional symptoms (threatened peritoneal abscess).

3. All acute cases where large indurations develop rapidly with high fever. Here extensive deposit and abscess are almost certain, and the operation should be early.

4. All cases advanced to the subacute and chronic state, with distinct induration and dulness (regardless of the temperature), since, in most such cases, pus is present.

5. All cases of undoubted chronic appendicitis with acute exacerbations, even if no indurations can be demonstrated. In all such cases the patient is in constant danger of perforation of the appendix and peritonitis, and removal of the organ reduces the risk.

Mr. Lawson Tait recommends[3] opening the appendix and draining it independently, instead of removing it. He thinks the

[1] *Maryland Med. Jour.*, May 3, 1890.
[2] *Boston Med. and Surg. Jour.*, May 22, 1890.
[3] *Liverpool Med.-Chir. Jour.*, January, 1890.

risks of the operation are diminished by this detail.

At the Leeds meeting of the British Medical Association, Mr. Treves went into the subject systematically, and laid down rules for guidance. He does not recommend operation till all inflammatory symptoms have subsided. The incision should be made over the dullest region; the abdomen should be opened just beyond the diseased area, and where no adhesions exist; the abdominal cavity should be shut off from the field of operation by sponges; all adhesions should be cut, the appendix removed, the proximal end well closed by two rows of sutures, and the abdominal wound closed without drainage.

Mr. Bennett May does not operate with so many elaborate details. He does as little as possible; tries to reach pus and then drains, cutting off appendix or removing foreign bodies when these present themselves.

GERTRUDE B. KELLY, M.D.

Cripps (H.) on Fæcal Extravasation; Flushing of Peritoneum; Recovery.—The case recorded here adds one more brilliant result to the growing list of recoveries after thorough washing of the peritoneum. Individually the case is so striking as to deserve special notice, and reads briefly as follows: Inguinal colotomy; bowel opened on the second day. On fifth day, 8 A.M., severe attack of coughing, followed immediately by severe abdominal pain. 1.30 P.M.—Continuous retching, intense pain, pinched face, cold hands and feet, pulse barely perceptible. Examination of wound showed that the sutures had torn out and that the opened sigmoid flexure was freely discharging into the peritoneal cavity.

According to the report of the case, the original portion of gut was found and resecured, and the whole peritoneum thoroughly irrigated, washing out a considerable quantity of fæces, all without the aid of anæsthesia. The immediate result was entire freedom from pain, and the secondary result, gradual reaction from collapse, no peritonitis, and recovery. No details need be given here.—*Brit. Med. Jour.*, March 1, 1890.

BLAIR GIBBS, M.D.

Kelsey on Stricture of the Rectum.—That certain non-malignant strictures of the rectum do not admit of local treatment, and may imperatively demand colotomy, is clearly shown in a case recorded by Dr. Kelsey. In this case the stricture dated back nine years, and the ulceration to an earlier period. This condition, complicated with numerous fistulæ running in all directions, both above and below, resulted in complete destruction of the lower five inches of the bowel, including both sphincters. The pain and distress, aggravated by the constant discharge of pus and fæcal matter, by day and by night, for years, present a picture of almost perfect misery. Inguinal colotomy here was performed for the double purpose of giving a free exit to the bowel and thereby relieve the chronic obstruction, and, secondly, to allow the extensive ulcerations and sinuses in the perineum and pelvis a chance to heal by removing the source of irritation consequent to the normal functions of the gut. The report goes on to show that according to results of the same treatment in similar cases, the operation promises almost entire relief.

Three months after the colotomy the ulcers and sinuses were nearly closed, the discharge per rectum barely perceptible, while the iliac opening was easily managed and free from the unmitigated filth of the previous condition.

The patient had gained about twenty pounds in weight, and was able to walk to opera-bouffe matinées. The point of pathological interest in the case is that the original lesion was a simple ulceration, without any syphilitic or tubercular infection.—*Med. News*, April 26, 1890.

BLAIR GIBBS, M.D.

REPORT ON DISEASES OF THE NOSE AND THROAT.

BY CHARLES H. KNIGHT, M.D.

Langmaid (S. W.) on the Causes and Treatment of Nasal Obstruction.—Nasal stenosis, partial and complete, may be (1) *permanent* or (2) *transient* (recurring).

In *permanent* obstruction the cause may be said to be local.

Transient (recurring) stenosis may have local or constitutional causes.

A case is cited giving a very graphic illustration of the second variety. Operative interference had been proposed, but

rest in bed, careful feeding, the administration of iron, the local use of cold and applications of vaseline, and finally moderate scarification of the turgid posterior turbinated bodies resulted in complete relief from the nasal stenosis.

In discussing the etiology of nasal irritation, the author has the audacity to intimate that the city of Boston is dirty, and that its dirt-laden atmosphere is responsible for much of the nose and throat trouble coming under his observation.

In referring to the treatment of stenosis when due to turbinated hypertrophy combined with septal deflection, the author wisely expresses a preference for a method which looks to straightening the septum if possible, rather than to destroying the turbinated tissue, and again calls attention to the simple procedure of forcibly pressing the cartilage over by frequent insertion of the finger.

In cases of nasal occlusion the nature and situation of the stenosis should always be first determined. It is more frequently septal than turbinated. Transient turgescence of the turbinates may have a constitutional origin, and hence the application of the principles of general medicine should go hand in hand with local treatment.

The paper concludes with a timely warning regarding the use of cocaine. It should be used only by the medical attendant as a local anæsthetic, and to facilitate diagnosis and the application of remedies. Its prolonged use results in vaso-motor paralysis, and the ultimate establishment of an œdematous condition. Moreover, the nervous system may become seriously affected, and the patient become the slave of cocaine Local bloodletting, cold, mild astringents, tonic medication, change of residence, and surgical interference, as indicated, are efficient substitutes.—*Bost. Med. and Surg. Jour.*, May 15, 1890.

McBride (Thos. B.) on Four Cases of Epistaxis of Unusual Severity.—These cases serve to show the inefficiency of styptics, and to introduce a new domestic remedy, suggested by Dr. D. Hayes Agnew, namely, cylinders of *bacon*, large enough to closely fit the nostril and long enough to reach the naso-pharynx.—*University Med. Magazine*, May, 1890.

In the *Kansas City Med. Record*, May, 1890, Dr. H. S. Douglas reviews the subject of epistaxis without suggesting anything new, and in the *N. Y. Med. Record*, April 19, 1890, Dr. A. H. Fridenberg recalls the sometimes forgotten but very excellent substitute for Bellocq's canula—rubber tubing.

Ball (J. B.) on a Case of Rhinolith.—The patient was a girl four years old who had had more or less nasal obstruction and offensive purulent discharge for eighteen months.

On examination, the right nasal passage was found to contain much purulent secretion. It was quite obstructed to respiration. About three quarters of an inch from the orifice a hard rough mass could be felt with a probe. The pus having been wiped away, a little wool soaked in a ten per cent. solution of cocaine was introduced for a few minutes, and an attempt was made to remove the mass. A spud could be easily passed underneath it, and it was felt to be fairly movable. Some small fragments were broken off, which were found to consist of calcareous matter, but in consequence of the hemorrhage further attempts had to be desisted from.

At the next attendance chloroform was administered, and the body was extracted without difficulty with a fine pair of forceps. It was found to consist of a nucleus, about the size of a pea, which was obviously a vegetable substance, but the exact nature of which was not determined. Around this was a coating of calcareous matter about an eighth of an inch thick. The surface was rough and nodular. The mass might be said to be a foreign body covered with calcareous matter rather than a rhinolith; but the question is one merely of degree, for rhinoliths have been shown to be invariably formed round a nucleus, which in most instances is a foreign body introduced from without, but may in some cases consist of a blood clot or a particle of inspissated mucus.—*Brit. Med. Jour.*, March 1, 1890.

Spicer (Scanes) on Nasal Obstructions and Mouth-Breathing as Factors in the Etiology of Caries of the Teeth and in the Development of the Vaulted Palate.—I. Mouth-Breathing—the consequence of nasal obstruction—appears to influence the production of caries in the teeth: 1. By increasing the stream of micro-organisms and of oxygen in the inspiratory air current. 2. By producing congested and inflammatory states

of the buccal mucous membrane, with increased secretion of highly acid mucus. 3. By desiccating the mouth secretions and so favoring their adherence, together with organic *débris* to the pits and irregularities of the teeth. 4. By the alteration of the position of the lips, cheeks, and tongue in retation to the teeth, so that the latter cease to be constantly scoured with saliva by the incessant action of the former. 5. By the substitution of a cold air bath for the warm bath of saliva which floods the mouth when it is shut, and flushes away collected matter.

II. (The hypothesis here offered was suggested by the well-known observations of John Hilton, as to the part played by the vomer and the sphenoidal sinuses in the formation and position of the hard palate.) The highly arched or vaulted palate, the contracted alveolar arch, and certain irregularities of the teeth of the upper maxilla are very frequently associated with chronic nasal obstruction in young persons. This association admits of a rational explanation of a hypothesis, that prolonged disuse of the nasal channels for their natural functions during growth leads to stunted evolution of the nasal framework. The septum and sphenoidal sinuses partake in this, and fail to push down the palatine processes of the maxillæ, while the rest of the face, including the freely used alveoli, continue to grow. The median line of the hard palate along the attachment of the vomer tends to retain its infantile position. The weight of the lower jaw—which drops to allow mouth breathing—acts through the tissues of the cheeks and presses on the superior maxillary alveoli, flattening each lateral curved half, so as to diminish the space available for the canines and other teeth which are therefore compelled to assume irregular positions. This theory is supported by the observations of Mr. Mummery, who has shown the freedom of savages and uncivilized people from these abnormalities of maxillæ and teeth. It is further borne out by the fact that removal of the adenoid vegetations and otherwise clearing away the nasal obstruction at the time of evolution of the hard palate and teeth materially assists dental treatment in rectifying the condition of the upper jaw, though these cases are brought to the rhinologist for other reasons.—*The Med. Press and Circular*, April 16, 1890.

Davis (Henry) on the Question of Anæsthetics in Operations for Adenoid Growths of the Naso-Pharynx.—The author's large experience entitles his opinion on this subject to no little weight. Having given chloroform a great many times without the slightest accident, largely in consequence, he thinks, of the position of the patient, the head being dependent at the end of the operating-table, he concludes that an anæsthetic should always be used. The surgeon can perform the operation more deliberately and with greater thoroughness ; the patient is spared much pain and discomfort, and, if unconsciousness is produced by one who is accustomed to this particular class of cases, it is as devoid of danger as in any other operation in surgery.—*Brit. Med. Jour.*, April 12, 1890.

Malloch (A. E.) on Partial Excision of Superior Maxilla for Epithelial Epulis.—The patient was a woman fifty-eight years of age. The tumor had been noticed only two months before the operation. There was nothing unusual in the operation, and the patient made a good recovery without disfigurement, the only external wound having been an excision in the median line of the upper lip.—*Montreal Med. Jour.*, April, 1890.

Rogers (W. B.) on Epulis, with Report of Five Cases.—Attention is drawn to the difference of opinion existing as to the clinical significance and proper surgical treatment of this class of cases. Some authorities, as Salter and Holmes, maintain that epulis is a benign growth, and that excision of bone is necessary only when the neoplasm has extended beyond the alveolus. The majority of writers teach that it is a recurring tumor of malignant tendency, and its site of origin should therefore be thoroughly excised. The author of the paper classes epulis with giant-celled or myeloid sarcoma. His cases are in many respects unusually interesting, and the results were good, the operation in each case including considerable healthy tissue.—*Memphis Jour. Med. Sci.*, May, 1890.

Lydston (G. F.) on Apparent Cancerous Transformation of Syphiloma of the Tongue ; Excision of the Tongue by the Galvano-Cautery.—The title indicates the important features of the paper. Several points are to be particularly noticed. The patient

was twenty-nine years old, contracted syphilis at eighteen, and had all his life been troubled with eczema of his hands. In the progress of his syphilis he had repeated attacks of buccal ulceration, was subjected to a very severe mercurial course, at least twice being salivated, received frequent local applications of acid nitrate of mercury, and continued the free use of tobacco and alcohol. Antisyphilitic treatment was at first effective, but afterwards futile. The patient finally died of hemorrhage from the mouth two months after the operation. The portion of tongue excised is said to have been sarcomatous, yet the microscopic examination seems not to have been altogether satisfactory.—*Western Med. Reporter*, May, 1890.

Donelan (James) on Supernumerary Tonsils.—After excision of both normally-situated but hypertrophied tonsils, in the case of a gentleman twenty-one years of age, the patient still complained of hoarseness, occasional dyspnœa, and a feeling as of some foreign body in his throat. The laryngoscopic mirror disclosed another pair of symmetrically placed tonsils low down in the pharynx. Removal with the guillotine being impracticable, the galvanocautery loop was used, after the parts had been sprayed with a 20 % solution of cocaine. The pain was so intense that removal of the opposite tonsil was postponed. Two days afterwards the latter was removed with the cautery loup. On this occasion also the pain was very severe in spite of preliminary injection and spraying with cocaine. The adventitious tonsils were situated behind the posterior palatine fold, and under the microscope presented the appearances characteristic of hypertrophied lymphoid tissue. The voice was restored by the operation.—*Brit. Med. Jour.*, May 17, 1890.

Baldwin (J. F.) on Intubation in Membranous Croup; Papilloma of Larynx Cured by Intubation; Intubation in Tubercular Laryngitis.—The case of papilloma was that of a boy eight years of age, the growth being attached to the margin and upper surface of the left vocal cord and to the anterior commissure. It was soft and very large. Attempts to remove it with forceps, both with and without an anæsthetic, were not successful. The tube, one of large size, was worn at night only for about a month, when the growth was found to have disappeared, except at the anterior commissure. To remove this portion of the growth two curette-like projections of gold-plate were soldered over the front of the tube. On the second withdrawal of this armed tube every vestige of the neoplasm was removed. There was no recurrence, and the voice was finally recovered.—*Columbus Med. Jour.*, March, 1890.

Saundby (R.) on a Case of Bilateral Paralysis of the Abductors of the Vocal Cords.—Among the more common causes of this condition, which is a rare one, may be mentioned—(1) Pressure on recurrent laryngeal nerves by tumor in neck or thorax. (2) Disease of medulla oblongata, involving the nuclei of origin of the accessory portions of the spinal accessory nerves, by which all the muscles of the larynx are supplied. (3) Cold.

Pressure on the recurrent laryngeal nerves may cause permanent partial paralysis of the abductors of the larynx, the paralysis being however so slight as not to be detected except by the aid of the laryngoscope; but, should the patient catch cold, the condition is so much intensified as to give rise to marked, and even urgent symptoms. A good example of such a case was mentioned by Dr. Saundby, in the *Lancet*, vol. ii., 1887, p. 898, the pressure on the recurrent laryngeals being in this case caused by a bronchocele. The cause of the paralysis in the case reported is not clear. The dyspnœa was so urgent that tracheotomy was done and the patient was still wearing the tube ten months later. It is suggested that the case may be of the myopathic variety, characterized by fatty degeneration of the arytenoideus muscle.—*Birmingham Med. Review*, April, 1890.

Sajous (C. E.) on Hoarseness in Professional Singers and Its Treatment.—The writer gives especial consideration to *perverted lubrication* of the larynx, to *inflammatory causes*, particularly catarrhal troubles in neighboring cavities, and to *impaired muscular motility*. The first-mentioned condition is aggravated by astringents and is most benefited by warm sprays of a saturated solution of potassium chlorate every two hours, and ten grains of ammonium muriate in a tumblerful of water at the same intervals.

The second condition can be successfully treated only by giving attention to the associated catarrhal inflammation of

the nose and pharynx. For local treatment of the larynx the best application for reducing the hyperæmia is a spray of resorcin, seven grains to one ounce, at first every two hours, then three times daily. When there is excessive hoarseness this may with advantage be preceded by an application of carbolized iodo-tannin, or a solution of perchloride of iron, twenty grains to one ounce.

The third condition is perhaps the most interesting, and has received the least attention. The larynx shows but little, if any alteration from the normal. This, of course, does not apply to paralytic or even true paretic cases, in which characteristic appearances would be present, but to atony of the muscles. The speaking voice is normal. The singing voice is generally alone affected, and that only in certain tones, though weakness pervades them all. The higher tones are generally "lost in the breath," that is to say, the passage of the air through the glottis is much more audible than the note proper, although in a small proportion of the cases the upper portion of the chest register may alone be affected.

The voice is sometimes markedly improved by a mild faradic current, the positive pole being applied behind the larynx below the inter-arytenoid notch, and the negative externally on each side of the thryroid cartilage. The point of the laryngeal electrode should be flattened from before backward and covered with chamois skin. For an external electrode I usually use the thumb and index finger of my left hand, the end of the battery cord being fastened to the palm. In this manner I can make the application with much more exactness over the location of the muscles I desire to influence on each side of the glottis, penetration being secured by frequently dipping my fingers in water. The length of the application depends entirely on the ability of the patients to stand the electrode in the larynx. It is generally well tolerated, owing to the fact that it does not enter the laryngeal cavity. Five minutes represents the usual time occupied in such cases. The electrode is introduced a few seconds, then withdrawn, then reintroduced, and so on, great care being taken to avoid touching the base of the tongue. A solution of the hydrochlorate of cocaine can be used to anæsthetize the spot upon which the electrode is to be placed, but the pernicious after-effect of this drug on the voice when the latter is to be used within a few hours renders the use of the drug undesirable.

Internally a pill composed of 1 gr. of quinia and ¼ gr. of nux vomica, administered every two hours, maintains the muscular tonicity. The curative treatment includes the electrical application three times a week, and iodide of potassium, 5 gr., gradually increased to 30, three times daily if the patient can bear it, which he will be much more likely to do if the iodide is administered in a glassful of water immediately after meals, and if three drops of Fowler's solution are given with each dose.—*Jour. Am. Med. Assn.*, May 3, 1890.

Johnson (H. A.) on Cancer of the Larynx, with Report of Two Cases.—The following are the author's conclusions:

1. An intrinsic cancer, localized, with no enlargement of the lympathics, should be operated upon as soon as its malignant character is determined.

2. An extrinsic cancer with enlargement of the lymphatics should not be operated upon.

3. Intrinsic cancers of the larynx are less likely to infect the system than extrinsic cancers.

4. Intrinsic cancers produce death by interfering with respiration; extrinsic cancers by general infection, but more especially by interfering with nutrition.—*Jour. Am. Med. Assn.*, April 19, 1890.

Garel (J.) on the Cortical Motor Centre and the Intra-Cerebral Fibres which Proceed from It.

1. There exists a cortical motor centre for the larynx in each cerebral hemisphere.

2. This centre is located at the foot of the third frontal convolution of the fissure which separates it from the ascending frontal.

3. The fibres originating from this centre pass to the level of the external part of the knee of the internal capsule, forming in the geniculate fassiculus a motor laryngeal fassiculus, independent of the fassiculus for aphasia and the hypoglossal fassiculus.

4. The laryngeal centre has a crossed action. Its destruction determines total paralysis of the vocal cord of the opposite side (cadaveric position).—*Jour. of Laryngol. and Rhinol.*, May, 1890.

Hope (G. B.) on Tracheal Ozæna.—Two cases of so-called tracheal "ozæna" are reported and the virtues of hydrogen peroxide as a remedy are extolled.

This condition has been elaborately described by Luc in the *Archives de Laryngol. de Rhinol.*, etc., vol. i., p. 101.

(It is discouraging to have this misnomer carried into the trachea, when it should long ago have been expelled from nasal nomenclature. Each writer who makes use of the term seems to mean a different thing. The latest addition to the confusion is in Billing's Dictionary, where "ozæna" is defined as "ulceration in the nasal cavities with fetid discharge." The word should be dropped from the vocabulary of those who profess to write with scientific exactness).—*N. Y. Med. Jour.*, April 26, 1890.

OCCASIONAL REPORT ON GENERAL SURGERY.

BY CHARLES A. POWERS, M.D.

Pilcher (L. S.) on Whitehead's Operation for Hæmorrhoids.—The author has operated on six cases of aggravated hæmorrhoidal angeiomata, and as a result of his experience believes that the method is the best adapted to this class of cases of any with which we are now familiar. He agrees with Wier and other observers, however, in feeling that Whitehead claims too great ease and celerity for the operation.

To the beginner the operation is one which requires much time and care. The operator should exercise much care in seeing that the excised tissue is symmetrically taken away.

Dr. Pilcher feels that the best results from this operation can only be obtained by avoiding injury to the sphincter muscle or to its nerves; by the preservation of all of the integument at the verge of the anus, and by the even, circular discission of the rectal mucous membrane above the growth. —*Annals of Surgery*, May, 1890.

Bryant (J. D.) on a Study of 250 Cases of Excision of the Superior Maxilla.—As the result of a careful study of the cases which he has been able to collate the author concludes:

1. That excision of the superior maxilla is not a dangerous operation.

2. That, contrary to general belief, excision of both superior maxilæ is not a specially dangerous procedure.

3. That while dangerous hæmorrhage is not frequent in this operation, still its effects are more to be feared than other results of the operation itself.

4. That removal of the upper jaw for removal of bony and fibrous tumors and the removal of naso-pharyngeal polypi is attended frequently with dangerous and fatal hemorrhage.

5. That ligature of one or both external carotids is a safe and commendable procedure when dangerous hemorrhage is apprehended as the result of operations on the area of their distribution.

6. That ligature of one or both of these arteries may delay the return and hinder the progress of a morbid growth if it be developing in tissues supplied with blood by those vessels.

7. That—all things being equal—ligature of the *common* carotid for the purpose of controlling the circulation of the external is unwise, unsurgical, and unwarrantable.

8. That complete removals are five times as fatal as incomplete removals of single superior maxillæ, irrespective of the nature of the disease and of the side removed.—*Annals of Surgery*, May 1890.

Phelps (C.) on the Treatment of Simple Fracture of the Patella by Wiring.—Whatever the opinions which may be held—the writer [C. A. P.] is among those who object to operative procedure in recent simple fractures of the patella—regarding the advisability of this operation, all will be very much interested in learning the technique of its most experienced and successful advocate.

Dr. Phelps has operated on forty-five cases during the past five years and his results have been excellent.

He makes the incision follow the sulcus made by the separation of the fragments, which is ordinarily nearly, or quite, transverse in direction. It should primarily extend across the knee, nearly from one transverse ligament to the other, and down to the anterior surface of the patella; secondarily, it should lay the joint freely open as far as the laceration of the synovial membrane extends on either side, or, better still, to the full extent of the superficial wound already made. Free opening of the joint cavity makes its examination, cleansing, and drainage more perfect, and

experience shows that there are no compensatory dangers. A drainage-tube is carried through the outer aspect of the joint where it is most dependent by means of a trocar and canula made large enough for its passage.

If the operation be done later than the first week, no clamp or ligature is likely to be required. The cavity of the joint is usually filled with blood and coagula, which continued irrigation will incidentally remove. No direct effort should be made to this end, for it is essential that the parts should be disturbed as little as possible. The fragments will be found to be separated by coagula and shreds of fibrous tissue with which they are interwoven and which hang down between the opposing bony surfaces, and more or less effectually prevent their contact. The exceptional instance was in the only case in which I have had a refracture. This fibrous tissue, with the entangled coagula must be detached from the fractured surfaces as far as their upper margin, and pushed back upon the upper surface of either fragment. This can be conveniently done with a Hebra's scoop. The clean bony surfaces can thus be brought in direct contact, which is the first condition of consolidation. The fragments are then to be drilled and brought together by heavy silver wire. The drill should be but little larger than the wire. A single wire will ordinarily suffice to hold the fragments in position.

After as perfect apposition has been attained as possible, the wire is to be twisted firmly, cut off rather short, turned over smoothly, and forced into the interosseous sulcus.

The closure of the joint cavity is to be effected by a continuous or interrupted suture of fine catgut, uniting the capsule over the patella and the deep fascia and synovial membrane on either side. This should be done with the utmost thoroughness and precision.

The skin wound should then be drained by horsehair and sewn up and the knee dressed and confined. It is needless to say that absolute rest is of paramount importance. Dr. Phelps retains a splint but three weeks; the patient is out of bed on the fourth week.—*N. Y. Med. Jour.*, May 31, 1890.

Keen (W. W.) on the Treatment of Floating Kidney. — This may be threefold: 1. By pad and bandage. This should always be tried first. 2. Nephrectomy. This is only occasionally justifiable. [It is a *dernier resort;* it should only be considered after nephrorrhaphy has failed.—C. A. P.] Its mortality is from twenty to thirty per cent. The mortality of nephrorrhaphy is only about two per cent. 3. Nephrorrhaphy. This was introduced into surgery by Hahn, in 1881. The incision is made obliquely between the last rib and the crest of the ilium, beginning over the outer border of the quadratus, the perinephric fat being cut or torn through. Either the kidney or the liver may be seen at once. The kidney may be so far away from its normal position that it will be necessary for an assistant to push it back. Mobility will not distinguish between the kidney and the liver, for a movable kidney will be as much affected by respiration as the liver.

Four methods of fixation have been recommended: 1. By passing the stitches through the fatty envelope of the kidney. This method is regarded as insufficient. 2. By stitching through the fibrous capsule of the kidney. 3. By passing the stitches through the parenchyma of the kidney. Only occasionally has any blood been found in the urine. 4. Splitting and stripping back the capsule to obtain cicatricial union between the raw kidney substance directly to the surrounding tissues. The stitches are passed through the parenchyma where still covered by the fibrous capsule. Only four cases have been operated upon by this method, a number as yet insufficient to form a judgment as to its merits.

The third method has given the author very good results. The kidney seems to tolerate the presence of sutures for a long time without trouble, but whether in the degenerative changes of old age, or when the general health fails, they may become a source of trouble, time has not yet shown. The author condemns the stitching of the kidney to the ribs on account of its dangers. Both extremities of the kidney should be secured by sutures, with four additional sutures, two passing through the anterior and posterior lips of the wound respectively, and penetrating the kidney substance. The material that the author selects is fine silk, and he advocates that the stitches should be left in place. He recommends that the ex-

ternal wound be not sutured, as it closes quickly.

In the after-treatment he lays stress on keeping the patient in bed for not less than a month, and when she begins to go about, a snug-fitting elastic bandage should be worn.—*Med. Record*, May 31, 1890.

Beach (H. H. A.) on Cancer of the Male Breast.—This is an occurrence of sufficient rarity (it forms about two per cent. of all cases of breast cancer) to render all recorded cases of interest. Dr. Beach's patient was forty-two years old. He had first noticed a small lump in the breast several years before, just below the nipple. It had grown without pain, and later a second lump appeared in close proximity to the first: together they were of the size of a pigeon's egg. Two weeks ago, after a hard blow received upon the tumor, it became inflamed, and discharged spontaneously. He entered with a deep ulcer on the left breast, having an irregular border of an inch and a half area, but without any enlargement of the axillary glands. An elliptical incision was made into the healthy adjoining tissue, and the mass cleanly dissected from the underlying pectoral muscle. A portion of the wound was united by stitches, and the remainder left to granulate. Microscopical examination showed the growth to be carcinoma.—*Boston Med. and Surg. Jour.*, May 15, 1890.

Kammerer (F.) on Arterio-Venous Aneurism of the Arm.—The man had a large mass occupying the inner aspect of the arm, and on the outer aspect there was the dilated tortuous cephalic vein receiving blood by a current from the median basilic and median cephalic; this mass of dilated veins extended into the axilla; there was a superficial artery on the inner side of the arm corresponding to the brachial artery, pressure on which, however, did not arrest the pulsation in the mass referred to, and therefore was not a direct factor in the condition. Pressure at site of the scar, and for an inch below it, would arrest the pulsation in the dilated veins on the anterior portion of the arm. The radial pulse persisted in spite of such pressure.—*N. Y. Med. Jour.*, May 10, 1889.

Vaughan (B. E.) on Outward Dislocation of Radius of Long Standing.—The patient, a young man of twenty years, injured the elbow when a child. Four weeks after the accident the deformity at the elbow was noticed, but no attempts were made to correct it. The head of the radius found a permanent resting-place on the outer aspects of the external condyle. The finger could easily be laid in the cup of its head. Despite this marked displacement all functions were complete.—*N. Y. Med. Jour.*, May 10, 1890.

Power (D'Arcy) on the Varying Effects of Violence in Producing Fractures.—At a meeting of the London Pathological Society, Mr. Power showed the knee-joints of a man, aged twenty-three, who had jumped out of a fifth-floor window and fell apparently upon his knees on the pavement. As a result of this fall, he sustained amongst other severe injuries fractures of both patellæ. Although the injury, so far as could be ascertained, was of exactly the same character in both legs, the results were strikingly dissimilar, for in the right leg the patella was fractured from within, so that the cartilaginous surface suffered severely, whilst the aponeurotic expansion of the quadriceps had escaped rupture. On the left side, however, the force had been so applied that the patella had been split from without inwards, or in an exactly opposite direction. At first sight this difference appeared difficult to explain, but on closer examination the author said that he had been able to show that the difference was due to the altered direction assumed by the force causing the fracture. In the right knee the fracture was produced by the violent impact of the articular surface of the patella against the unyielding condyle of the femur. On the left side, however, the force had been so applied that the patella acted as a wedge and split the condyle against which it was driven and which had itself received no injury.

[It is well nigh impossible to absolutely predicate the results of a given traumatism where the force is applied to bone. A very slight change in the amount or direction of the expenditure will materially influence the result.—C. A. P.]—*Brit. Med. Jour.*, April 19, 1890.

Wyeth (J. A.) on Exsection of the Knee-Joint for the Relief of an Old Traumatic Backward Dislocation of the Tibia; Recovery.—The patient was a man, twenty-seven years of age, who, when three years old had received a trau-

matic dislocation of the knee, which had not been reduced. Some inflammation had followed this injury for two or three years, after which, except for the shortening, the knee had given him no great inconvenience until within the last few weeks, when it had become quite painful. On June 3, 1889, he was admitted to the hospital. The left femur overrode the tibia about two inches. The shortening was greater than this on account of the undeveloped condition of the limb. Several scars indicative of old sinuses were seen about the joint. On June 11th, excision was performed. There was no disease of the bones or capsule. The ends of the bones were misshapen from abnormal pressure. About two inches of the femur and less than an inch of the tibia had to be sacrificed in order to bring the bones in apposition in the straight position. Fixation was secured with steel drills. Recovery with a useful, straight limb followed.—*Intern. Jour. Surg.*, April, 1890.

Langhorne (T.) on a Case of Intussusception of Nine Days' Duration Successfully Treated by Inflation.—The patient was an infant of nine months, who had suffered for nine days with evidences of acute intestinal obstruction, passing only blood and mucus. When seen, the baby was in collapse, abdomen distended and tympanitic, face pinched, hands cold. Under chloroform the invaginated gut could be felt by rectum, and a sausage-shaped tumor was made out in the left iliac fossa. The rectum was gently distended with an ordinary bellows, when the tumor was felt to disappear. The child made an uninterrupted recovery.—*Lancet*, May 3, 1890.

Connor (P. S.) on the Treatment of Tumors of the Bladder.—In a paper read before the American Surgical Association at its last annual meeting, the author states his belief that all cases, except the least severe and the most severe, should be subjected to operation, and that the supra pubic route to the bladder should be employed in males. Also that the removal should be made as complete as the situation and extent of the growth will allow.—*Boston Med. and Surg. Jour.*, May 22, 1890.

Smith (S.) on the Treatment of Fractures of the Shaft of the Femur in Adults.—Treatment should consist in extension in a straight-line position and the adjustment of suitable coaptating appliances to the limb at the seat of fracture. Of the methods of making extension, none can compare in efficiency and comfort to the patient with rubber plaster to the leg and the weight attached to the stirrup at the foot, with counter-extention by elevating the foot of the bed. Of the coaptating appliances, none exceeds the plaster-of-Paris dressing.

The first requisite is a suitable bed with a firm surface, with an opening for the passage of the evacuations. The foot of the bed is elevated four to six inches.

Extension should at once be commenced. The preferable extending apparatus is the rubber plaster and weight. When the rubber causes irritation, it may be replaced by a plaster-of-Paris dressing to the foot and ankle, around which a cord may be fastened for the attachment of the weight. The weight should be sufficient to extend the muscles to the desired length, so as to bring the ends of the bone in apposition. A good general rule is to apply as many pounds as the patient is years old, up to twenty, but the effect sought is the better guide.

Four coaptating splints should next be applied to the whole length of the thigh and firmly compressed by four stout tapes. These splints should be of light wood and of such width as to nearly touch each other. This treatment should be continued for five or six days, at which time the limb should be in condition for the application of a permanent dressing.

No change is to be made in the extension, but the splints are to be replaced by a plaster-of-Paris dressing. A roller bandage of heavy blanketing is first passed around the thigh, commencing just above the knee and extending as high as the waist-line. The plaster bandage is then applied until three layers are added. When the bandage reaches the fractured bone, a mass of cotton wadding is applied to the lower end of the upper fragment, and an assistant presses the bone firmly in contact with the lower fragment, and maintains this pressure until the entire bandage is applied. If, when the bandage has hardened, it is too tight at any point, it may be cut sufficiently to relieve the pressure. This bandage should be continued in position at least six weeks, and if in good condition it may be retained eight weeks.

At the end of four weeks the extension may be discontinued and the patient may move about on crutches. If the splint becomes loose, it should be cut along the outer and posterior part and then tightened with three or four straps with buckles.

[The foregoing notes are not presented on account of their novelty, but because of the sterling value which attaches to this method. It is by far the most satisfactory of any with which we are now acquainted. One may prefer well-fitting coaptation splints to gypsum at the seat of the fracture; he may find the adhesive plaster preferable to rubber plaster; he may not agree with Dr. Smith that it is wise to allow patients to walk at the end of four weeks; but these are minor details—the main point is the extension and counter-extension applied after the method of Dr. Buck.]

Dennis (F. S.) on Compound Dislocations of the Ankle-Joint.—The author emphasizes the value of treating these important cases by immediate and thorough asepsis to the entire limb, irrigation of the ankle-joint, free drainage through and across the joint, immobilization by plaster-of-Paris, removal of the tube on the third day, and recourse to gentle passive movements at the end of the third week. Employment of these measures has afforded his patients, during the repair of the injury, freedom from pain, fever, and suppuration, and they have recovered with perfectly useful joints.—*Intern. Jour. Surgery*, March, 1890.

Myles (T.) on Extra Articular Suture in Fractured Patella.—The author, seeking a method by which closer apposition of the fragments of a broken knee-cap could be maintained, devised the following procedure:

The limb being cleaned, the skin is drawn well up; a small puncture is then made through the skin on either side with a common bradawl; the upper fragment is cautiously drilled from side to side, the drill being constantly kept accurately parallel to the anterior surface of the fragment; through the drill hole a stout nickel-silver pin is passed, its two ends project on either side of the fragment, its centre is buried in the substance of the fragment. The lower fragment is then similarly drilled and transfixed, the skin having been previously drawn well down.

When the fragments are drawn together and fixed in proper apposition, a gauze tape can be passed under and around them in a figure of 8, as in a hair-lip operation, or the free ends can be securely wired together.

A thick pad of lint, dipped in perchloride solution, 1 in 500, is wrapped around the joint.

A posterior splint and flannel roller completes the dressing, which is not stirred for five or six weeks.

The advantages claimed for the method are:

1. That it is effective—that is to say, it will keep the fragments in perfect apposition without the tilting incidental to mechanical appliances.

2. It is free from the danger of septic infection, as the joint is not opened.

3. It is easy and simple, and within the reach of every one, requiring no costly appliances.—*Dublin Jour. Med. Sci.*, Nov., 1889.

McGill (A. F.) on Trephining the Ilium for Iliac Abscess.[1]—The patient was a girl of eighteen years, who complained of pain in the right iliac region and thigh, the right hip having undergone excision five years previously. Deep fluctuation was detected in the right iliac fossa and the aspirator withdrew six ounces of pus. Aspiration was repeated three days later, and five days after this second aspiration, the temperature being hectic in character, Mr. McGill opened the abscess above and behind the anterior superior spine of the ilium. A considerable quantity of pus, escaped. On passing the finger into the abscess-cavity a piece of the iliac fossa the size of a sixpence was felt to be denuded of periosteum. Over this spot, situated five inches below and behind the anterior superior spine, a transverse incision was made, dividing the skin and glutei muscles down to the bone. A three-quarter inch trephine was applied, and a portion of bone this size, including all that was bare of periosteum, was removed. The abscess cavity was thoroughly scraped in all directions, and freely irrigated with a solution of perchloride of mercury. A drainage-tube large enough to fit exactly into the trephine opening was inserted, and the wound above the iliac crest was closed with sutures. A large antiseptic wool dressing was applied.

[1] See similar case by Terrillon, THE MEDICAL ANALECTIC AND EPITOME, 1890, p. 141.

The after-progress of the case was in every way satisfactory. There was a copious serous discharge, which necessitated frequent changes of the dressings for forty-eight hours. The temperature dropped to normal on the second day, and never again reached 99°.—*Lancet*, April 5, 1890.

Monks (G. H.) on a Case of Appendicitis in the Scrotum.—The patient was a boy of thirteen months, who, when first seen, suffered from the presence of an inflamed swelling which occupied the right half of the scrotum and extended up the inguinal canal. Aspiration withdrew a small amount of pus and the acute symptoms then subsided, a tumor, however, persisting. Incision over this revealed a structure two inches in length and the thickness of a lead pencil, which microscopic examination proved to be the vermiform appendix surrounded by thickened tissue. It was excised, the patient making a rapid recovery.—*Boston Med. and Surg. Jour.*, June 5, 1890.

Deaver (J. B.) on the Diagnosis of Extra-dural Hemorrhage.—While the treatment of this very important class of cases justly comes within the provinces of the surgeon their recognition most often falls to the lot of the physician, and the following points collated by Dr. Deaver are of interest and value. They differ but little from those given by Jacobson in his interesting monograph published in the *Guy's Hosp. Reports*, for 1887 :

Mental Condition.—May be normal, or there may be cerebral irritation. Unconsciousness, complete or incomplete, or coma.

Condition of Pupils.—May both respond to light normally. May both be dilated and show no response; or one may be widely dilated and the other normal. When the dilated pupil corresponds to the injured side, it is caused, as pointed out by Hutchinson, by the pressure of a large clot, extending deeply down into the base of the skull, on the cavernous sinus, leading to fullness of the vessels, with protrusion of the eyeball, and dilatation of the pupil. It is also accounted for by compression of the oculo-motor nerve by the clot.

Respiration.—May have stertorous breathing, Cheyne-Stokes respiration, or cyanosis.

Pulse.—Little changed, or rapid and feeble, depending largely on the severity of the concussion; or slow and full, depending upon the severity of the compression.

Limbs.—May present any of the following conditions: Hemiplegia, well or but little marked. On the same side as the one injured, indicating hemorrhage on the opposite side; monoplegia, paralysis, twitching, convulsions, rigidity (spastic).

Scalp.—Presence of contusion, or bogginess due to the injury; the latter also due to leakage from within the cranium through a fissured fracture.—*Jour. Nervous and Mental Disease*, Feb., 1890.

White (J. W.) on the Modern Treatment of Vesical Calculus in Male Children.—The author, following closely the deductions reached by Keegan, believes that in every case of calculus in male children litholapaxy, on account of ease of performance, low mortality, speedy recovery, and absence of danger of emasculation, should be the operation of predilection, division of the meatus being freely resorted to if that portion of the urethra offers an abstacle to the introduction of instruments. He would traverse the supra pubic route to the bladder only in cases of large and hard stones, and he would reserve perineal lithotomy for cases of small calculi in which no lithorite, however small, can be introduced.—*Med. News*, May 17, 1890.

REPORT ON DISEASES OF THE EAR AND EYE.

BY A. T. MUZZY, M.D.

Lockwood (T. C.) on Old Mastoid Abscess Treated by Free Drainage and Tincture Iodine Applied to Abscess Cavity.—In July, 1889, a laborer consulted us about a mastoid abscess which he has had for a number of years. This has been incised and evacuated after varying periods of poulticing whenever troublesome, the relief being temporary and partial. The man seemed robust and gave no history of disease of the ear or syphilis, the abscess being due perhaps to lymphatic inflammation of scrofulous origin. Examination showed infiltration of tissues over mastoid, a small area of fluctuation, brawny swollen condition of major portion of post-cervical region to occiput, interfering with rotation of head.

Under ether a free incision was made and the bone found healthy. A counter-opening was then made in upper part of posterior triangular space, and the cavity swabbed out with a mixture of two parts tr. iodine to one part glycerine. Drainage was instituted with antiseptic dressing. After considerable inflammation healing was complete.—*Maritime Med. News*, March, 1890.

Fergus (F.) on the Examination of the Eye.—Conjunctivitis is often only an expression of faulty refraction. In some cases the face denotes from its shape and expression the astigmatic and the myopic and hypermetropic conditions. Acquaintance with these forms are good things to know as a starting point for one's examination. And though it is quite impossible to draw any complete and infallible scheme for examinations, yet a few points should always be noted as far as circumstances permit. Thus all chronic and persistently recurring irritations of the lids should lead to an early examination of the refraction of the eye. Often will it be found that a glass correcting the faulty refraction, which may be latent as well as apparent, puts an end to the conjunctivitis, blepharitis, hordeola, or other lid trouble. As is well known, the development of the eye is somewhat dependent upon the development of the orbit and face. So it is not strange to expect with a flat face to find the eye flat or hypermetropic. On the other hand, when we have a myopic eye to deal with, we shall generally find it associated with a cranium of long antero-posterior axis, or else deep orbital cavity and marked prominence of the natural eminences of the face. There is another form of myopia face, viz., where there is protrusion, exophthalmos of the globe. Especial attention should be given to the *astigmatic* face. While this irregularity between the different meridians of the cornea may exist without any special configuration, very often it is. Thus in some the chin will be found deflected to one side, that is development of the face has been unequal. But in astigmatism there is the peculiar position in which the head is held as well as its configuration. Very often the face is rotated so as to bring the best meridian of the cornea in line with the object looked at. Often in *ametropia* we find slight and frequent twitchings of the orbicularis muscle, the eye looking painful and tender. These movements affect only the peripheral fibres, and generally those of the inner part of the lower lids. These should be distinguished from movements affecting the whole of the lids.—*Glasgow Med. Jour.*, March, 1890.

Alt (A.). A Case of Sarcoma of the Iris in a Child Two Years Old.—The child, of healthy parents, two years old, gave a history of good health until within six months, when she began to scream out in the night and otherwise sleep restlessly. The right eye was of dull appearance and the iris bound down to a cataractous lens. The iris was nodular, swollen, with gelatinous semi-transparent surface. Tension of the globe was normal. The incisor teeth were notched, but the glands of the neighborhood were not swollen. The left eye was normal. No specific history was obtainable, and specific treatment had no effect on the ocular condition. The nodules increased in size, while tension remained normal. Two weeks later tension had risen to + 2. And there were two staphylomatous elevations of the sclera near the corneal border with considerable episcleral injection. After enucleation histological examination showed sarcomatous growth of iris.—*Am. Jour. Ophthal.*, Feb, 1890.

Theobald (S.). Notes of Two Cases of Squint and One of Esophoria, Due to Anisometropia, in which the Muscular Anomalies were Cured by Glasses; also of a Case of Esophoria of Unusual Degree.—Cases of squint cured by use of proper glasses are comparatively rare. Success, if attained, is due to one of two causes; first the squint may be immature, existing only during accommodation; or, if an old standing one, changes are taking place in the relative strength of the opposing recti muscles. If anisometropia is present there is also chance of success without operative procedure. In some cases of anisometropia one eye is used for near work and the other for distance. Case I, a woman, aged thirty years, complaining of asthenopia, showed slight convergent squint. Examination showed compound hypermetropic astigmatism in the right eye, which she employed for distance; and compound myopia astigmatism in the left, used exclusively for near work. Under constant use of proper glasses the squint

entirely disappeared in a few weeks. Case II, a woman, forty-two years old, with a decided divergent squint of the left eye for distance, but vacillating and even disappearing momentarily in near, showed simple myopic astigmatism of right eye, and simple hypermetropic astigmatism of left eye. Examination by prisms gave very contradictory evidence. Four or five days' use of the proper lenses produced binocular fixation and disappearance of all signs of asthenopia. Case III, a doctor, thirty years old, a teacher, and complaining of asthenopia, was found to have compound myopic astigmatism in each eye with anisometropia. Five months' use of proper glasses showed a complete disappearance of esophoria amounting to 5° at 20′ and hyperphoria of 1° +.—*Am. Four. Ophthal.*, Feb., 1890.

Roosa (D. B. St. J.). The Relation of Errors of Refraction and Insufficiency of the Ocular Muscles to Functional Diseases of the Nervous System.—About thirty-three years ago, Donders found the profession striving to prove that asthenopia was due to defective action of the external muscles of the eye, but he demonstrated it as arising from two causes: either a short eye-ball, hypermetropia, or from some constitutional disturbance, such as occurs in a marked way in paralysis from diphtheria. If he had known as much of the effects of astigmatism as he and Knapp have shown us of its nature, he would have added astigmatism. The conclusions to which I have come as a result of twenty-six years of work in ophthalmology, with a careful consideration of the writings and works of others, including those who believe that functional nervous disease is due to the eye "more than to all other causes combined," are as follows: First. The eyeball of the human race is very rarely in what might be defined as an emmetropic condition. Second. Perfect equilibrium of the ocular muscles is by no means a common condition, even among persons of sound health and without asthenopia. Third. Defects in those two states by no means necessarily produce even local disturbances, such as are comprehended under the term of asthenopia, inflammation of the edges of the lids, and so forth, although high degrees of hypermetropia, moderate degrees of astigmatism, and all cases of mixed astigmatism are apt to do so, sooner or later. Fourth. Asthenopia depends chiefly upon two sets of causes—nervous exhaustion and uncorrected errors of refraction. Fifth. In estimating the influence of these defects, great stress should be laid upon the general condition, and the line sharply-drawn between asthenopia due to exhaustion and that to faulty refraction. Sixth. Nothing has been added essentially to Donders' discovery of the fundamental cause of accommodation asthenopia, except that astigmatism forms a more important factor in its etiology, muscular asthenopia falls into the background, while the definition of asthenopia has been much amplified by ophthalmologists. Seventh. The origin of a considerable class of such diseases, as chorea, epilepsy, and hystero-epilepsy has not been found in errors of refraction nor in insufficiencies of the muscles of the eyeball. Certainly a discovery which was thought would rival those of Jenner and Lister, and which has been so widely heralded, and acted upon, is not, in my opinion, an advance in rational and scientific therapeutics. And often, by distracting attention from the evident, and in some cases preventable causes of neuroses, has delayed our progress, and inflicted serious damage to the reputation of our profession for accurate observation. —*Med. Rec.*, April 19, 1890.

REPORT ON ORTHOPÆDIC SURGERY.

BY JOHN RIDLON, M.D.

Willard (De F.) on the Operative Treatment of Hip-Disease.—I trust that it will not be inferred from the title of this paper that I look upon the operative treatment of hip-disease as the chief element in the management of this affection; on the contrary, I regard mechanical and hygienic measures as of the greatest importance, and acknowledge that operative procedures are, like amputations, confessions of defeat; yet operative measures are necessary in a considerable number of cases.

As to the necessity of operation, much will depend upon the condition and surroundings of the patient. It is very justly claimed that in many cases operative means are unnecessary, and there are many surgeons who hold that excision is

never necessary. Personally, I can say, as regards the value of careful attention to detail and the application of strict mechanical control, that I consider them so valuable that I have never yet excised a hip-joint in private practice where the individual has been under my care from the inception of the disease. I believe that it is very rarely required under such circumstances, but there come to all of us a great mass of cases with hips riddled with sinuses, pouring out quantities of pus, whom we cannot treat with any certainty that a single instruction will be thoroughly followed, and, with the almost absolute certainty that the disease will rapidly progress or that death will follow. This class of cases stands upon an entirely different basis and must be treated in the way that will give the best results in the shortest time, and we cannot hope to accomplish even that little unless they are received into the wards of a hospital. Instructions that are disobeyed, apparatus that is misapplied, can never give good results.

Before operating it is important that we consider three questions :

1. Is life saved ?
2. Is time gained ?
3. Is the resulting limb more useful ?

1. Is life saved ? To this question properly would require a careful study of what may be called the natural death-rate from hip-disease practically untreated, and secondly, when carefully treated with the utmost attention to every detail, and by various forms of mechanical appliances. It is exceedingly difficult to classify the statistics upon this point, because there are only a few cases in which a certain form of treatment is not instituted ; and secondly, even with apparatus there is the greatest diversity of methods. In the large majority of cases, moreover, treatment is interrupted by the patient being placed in the care of some other physician, and thus the course of the case in its entirety is lost and it becomes valueless as regards statistical importance.

The saving of life is, of course, the most important consideration of the surgeon, but, if the question were to be considered from this standpoint alone, we should at once join the ranks of those who advise early excision, since the risk from operation at that stage would not be great with asepsis, and in many cases of tubercular infection death would be avoided. Carrying out this line of reasoning, we should arrive at the *reductio at absurdum* that all cases of hip inflammation should be excised so early that there would be no possibility of the disease being more than a local difficulty.

2. Is time gained ? With the practice of antisepsis, which favors rapid healing, we frequently obtain speedy closure of the wound. If any one wishes to have excellent statistics, let him report all cases about the sixth week "perfectly healed." But wait a few weeks more ; a small sinus appears, a long period of suppuration follows, and the patient either finally dies, or is cured at the end of possibly a little shorter period than would have been occupied by a natural cure, but the limb is less useful as a walking member.

3. Is the limb after excision as useful as the one which nature, assisted by the surgeon's care, is capable of securing? In the large majority of cases, unquestionably no ! The loss of the bone, even in one of the worst cases of disintegrated tissue, is seldom as great as in complete excision where the trochanter major is sacrificed. Even in suppurative cases, where there has been absolutely no operative interference, where the joint has been thoroughly fixed, and even although ankylosis has followed, the result is an excellent walking member, and the vertebral column (especially in a child) gives wonderfully compensatory movements. For the working man or woman a stiff joint is incomparably better than one in which the pelvis is insecurely steadied upon the femur, while extensive resection in early childhood may, by the removal of the epephysis, so interfere with the growth of the member that the limb may be rendered almost useless as a functionating part of the body. The report of the London Clinical Society was decidedly of the opinion that the result was less useful, and I must confess that my results after excision have not been satisfactory, even when treated with care, with rigid antisepsis, and with subsequent attention to fixation of the joint for one or two years. A large majority of cases, six months after leaving the hospital, have been found to be suppurating. I speak of hospital cases, as, under proper care, operation is seldom necessitated in private practice.

CONCLUSIONS.—I. Mechanical measures, which enforce strict and long-continued rest

of the joint, are the best preventives of operative procedures, and when they can be employed, as in private practice, operation is seldom necessary, since even if caseation or liquefaction occurs, we may often have absorption or encapsulation. Give careful attention to hygiene and general health.

II. Antiseptic aspiration of the joint is desirable if it is distended with serum, sometimes when it is filled with pus.

III. Ignipuncture and trephining give great relief, provided the focus of the disease is reached.

IV. If in doubt as to the presence of pus, wait, or test with aspirator. Repeat the aspiration if the fluid drawn is seropurulent, since organization may occur without the opening of a sinus. If there are no signs of caseation, wait. If caseation takes place, make early exploratory incision. These latter cases are often curable by simple incision and drainage.

V. When certain that true pus has formed, aspirate and inject with iodoform in order to strengthen the walls of the abscess cavity as a preliminary to incision, provided incision alone is decided upon.

VI. If the abscess is to be only opened and no other operation performed, as soon as the sac refills after aspiration incise freely, wash out the contents with a slow current of (1-1000) hot sublimate solution, but on no account apply pressure to expel the pus, lest fissures be made in the limiting wall and infection be thus favored. Drain freely. Dress antiseptically, and fix the hip. Continue to keep it at rest until closure occurs, or until further steps are necessary.

VII. When extirpation has been decided upon, make an exploratory incision either along the line of a sinus or directly upon the bone, anteriorly or posteriorly, as preferred, and thoroughly examine the joint. If the destruction of tissue is small, try erasion, and remove the carious bone and soft tissues with scoop, scissors, and knife. Endeavor to remove every particle of tuberculous tissue of both hard and soft parts including the abscess wall. Irrigate thoroughly with a strong antiseptic to prevent bacillary infection of the freshly-cut tissue, and drain freely. With antisepsis the dangers of opening the joint are only slight, and the desirability of operation is now based largely upon the question of time and the ultimate results as regards usefulness of the limb. In children it is especially desirable.

VIII. Perform a formal excision, not as a routine practice, but when the disease is found to be too extensive to be removed in any other way. In adults, especially when poor, a typical resection gives the best results. In cases of great destruction of bone, in painful caries sicca, in profusely suppurating cases, in the early stage of commencing waxy changes, the operation becomes one of special value.

Erasion differs from excision chiefly in the fact that in the former operation all diseased tissues (soft and hard) are removed, and all healthy ones are spared. It is also less mutilatory. In excision a considerable portion of the good bone is sacrificed, but erasion is, of course, not as beneficial at the hip-joint as at the knee.—*Med. News*, April 5, 1890.

McKenzie (B. E.) on the Treatment of Hip-Disease.—The practice advocated in this paper may be briefly summed up:

1. Constitutional treatment, such as is employed in other wasting diseases, is of prime importance in all cases.

2. In early stages of the disease, treatment by rest for the joint is indicated.

3. Rest can be better obtained by employing a portable fixation apparatus than by any means requiring confinement in bed.

4. Deformity if not fixed by adhesions or contractured muscles, may be corrected by the use of portable splints.

5. Deformity, maintained by contractured muscles and adhesions about the joint, may frequently be corrected by myotomy or tenotomy, and the adhesions broken up by using a moderate degree of force.

6. When deformity cannot be so corrected, osteotomy should be performed.

7. If faithful trial of these means fail to give satisfactory results, excision or amputation should be performed.

8. Pus, or sequestra, when known to be present, should be removed by operation.—*Canadian Practitioner*, April 16, 1890.

Young (J. K.) on Shortening of the Femur from Epiphysial Inflammation.—The case was that of a boy of eight years, whose right femur was two inches shorter than the left, and whose history, upon close study, presented several etiological factors of great interest.

There was no history of nervous disease or deformity, and the family history was good. Both parents are living and healthy, the patient being the second of four children, each of whom has developed soon after birth what was believed to be icterus neonatorum. The disease in this child began on the seventeenth day after birth with intense jaundice. Three days later a small abscess formed on the back of the left hand, followed shortly after by one in front of the elbow-joint which communicated with the articular cavity. Later, abscesses formed on the inner aspect of the right thigh, at the junction with the perineum, and two on the outer side of the trochanter. (It is uncertain whether these last communicated with the joint, but they present the appearance of post-articular abscesses.) The abscesses were opened, and a probe was passed into the elbow-joint. Extension was made of the right lower extremity, and three weeks later the child was well and has remained so since.

On examination, Jan. 13, 1890, the right lower extremity measured in length 33 inches, the left 35 inches; the right thigh 12 inches, the left thigh 14; the right leg 11 inches, left leg 11 inches. All the joints of the lower extremity are normal in anatomical construction and functions except the right hip-joint. About this joint there is some induration, and the great trochanter is one inch behind the Roser-Nelaton line; abduction, adduction, forced flexion, and extension are normal, the foot is in a normal position, and no grating within or about the articulation could be detected on the closest examination. There is a slight atrophy of one half inch of the adductors. The circumference of the calves are the same. In the left elbow-joint the olecranon is slightly luxated posteriorly, but motion in this joint is perfect.

In conclusion, we believe all the children were probably infected with septic material through the umbilical vein, resulting in jaundice as a marked sympton, and that in this child the infection was more severe, resulting in purulent arthritis of the elbow-joint, abscesses, and partial destruction of the diaphyso-epiphysial cartilage of the right femur.

In recording this case the writer has only dwelt lightly upon the subject of epiphysitis or acute suppurative arthritis of infants, about which so much of value has been written of late, and the literature of which is readily accessible, and has recorded the case simply on account of the peculiar history and the shortening of the lower extremity which resulted.—*Am. Jour. Med. Science.*

Taylor (H. L.) on the Rational Treatment of Hip-Joint Disease.—There is little to encourage the practice of routine in the surgical treatment of hip-joint inflammations. Nothing can take the place of a critical analysis of the patient's general state, the condition of the joint and neighboring structures, and the nature, grade, and stage of the inflammation upon which to base our management. What is required at one time is harmful at another, and no one apparatus or device will meet the varying indications in the progress of the disorder.

Briefly, in the acute stage the patient is put to bed and counter-traction made by means of the long splint reaching under the foot. The five-tailed adhesive plasters are so applied that the knee is protected from damage, and the leg rests in a sling, which is elevated until the small of the back rests on the bed and traction is in the line of the deformity. Lastly, six to twenty pounds extra weight is attached to the apparatus, which is positive in its action, and protects the joint from shock or undue pressure under all ordinary circumstances. The patient is kept continuously in bed until the hip muscles are well relaxed and the deformity due to spasm overcome; usually from three to six weeks are sufficient in a tolerably advanced case. He is then allowed to get up with the splint applied, either walking on the perineal strap of the apparatus, or using crutches and allowing the leg to hang.

Traction by the apparatus is kept up continuously, day and night, and the weight is still worn at night. The splint is never removed except to change the plaster, when traction must be maintained by a weight fastened to the ankle, or by the hand. Frequent manipulations of the joint should be avoided, and riding should be forbidden, on account of the jarring, which is most harmful. The patient thus goes about on his traction splint quite comfortable, and able to take the fresh air, until irritation in the joint is allayed, which usually takes several months or a year. When all active inflammation has subsided, and the healing process is progressing favorably, the hygiene of the joint requires

moderate, protected use, within defined limits. We then use the supporting splint, or Dow's, with free joint at the knee and ankle, transmitting the patient's weight from the perineal strap to a steel piece in the shoe, through the apparatus, which is longer than the leg. There is about three fourths of an inch space between the heel of the foot and the sole of the shoe, so that free locomotion, with little or no pressure on the joint, is possible. There is no doubt that the protracted use of the muscles and joint, once the inflammation has subsided, benefits the local nutrition and circulation, and accelerates the reparative process, as is often shown by the drying up of old sinuses, and increase of motion at the joint and of strength in the limb.

This treatment must be kept up until the reparative process is completed, the tissues consolidated, the function of the limb restored so far as may be, and the joint prepared for the strain of unrestricted use. As the patient is perfectly comfortable and has good use of the limb, he is independent of time, and can ill afford to compromise nature's reparative efforts by submitting the recently diseased joint to premature use. It is this careful after-treatment of the joint, during which the patient frequently goes to school or attends to his ordinary duties, that prolongs the treatment in many cases. If these patients are too soon permitted to walk about without protection to the joint, there is danger of relapse, recurrence of deformity, and diminution of motion and of usefulness of the limb.—*Times and Register*, April 26, 1890.

MISCELLANY.

Allen (C. L.) on a Case of Plastic Bronchitis in a Child.—The patient, a previously healthy child, aged seven, first complained of pain in the left side of her chest and of nausea. The following afternoon she had grown worse, vomited occasionally, had considerable fever, restlessness, cough, and dyspnœa. Temp., 103.3°; pulse, 150; respiration, 60. On physical examination there was found some dulness and a few fine râles below the left clavicle; breathing slightly bronchial; lower down, slightly tympanitic percussion note. Two days later, the child was seized with a fit of dyspnœa, and coughed up a cast of the bronchial tube. Again, two days later, she coughed up another cast. The abnormal signs grew gradually less, and in a week she was quite well.

The casts were coughed up with some fatty mucus, and were pinkish-white in color. They were partly hollow, a probe entering a short distance only. On microscopic examination, a piece of the second cast was found to consist of fibrin, with a large number of leucocytes.—*Med. Rec.*, April 5, 1890. E. S. B.

Byron (J. M.) on the Tenacity of Experimental Rabic Virus.—From the author's experiments the following conclusions are formulated:

1st. The virulence of rabic cords is not sensibly affected by old age, if they be kept aseptic, and in proper conditions of temperature and humidity.

2d. Moderately high temperatures acting in experiments in tubes, have an attenuating influence on virulent cords; atmospheric temperature influencing inoculated animals seems to affect the virulence, but further experimental data are needed before deriving any definite conclusion.

3d. Putrefaction does not relatively affect the virulence in a reasonable length of time.

Researches of the Loomis Laboratory, No. 1, 1890.

Ponfick on Surgery of the Liver.—It has been believed hitherto that it was impossible to remove large portions of the liver, owing to the necessity of exposing specially sensitive organs, to the probable derangement of nutrition for want of bile. From experiments which the author has made on rabbits, it was found that the removal of the fourth part of the liver caused only a slight deterioration in the general condition. The removal of the half caused a much more serious deterioration, which, however, passed off in a few days. Even the removal of three quarters was borne, though with very severe prostration at first. A considerable number of the animals survived this last operation, and recovered entirely. The excision of more than three quarters of the liver did not succeed. It was found, further, that the liver had an astonishing power of repairing lost tissue. Within a few days the mutilated organ grew to more than its original size.—*Lancet*, April 19, 1890.

Issendowsky (A. J.) on Menthol in Laryngeal Tuberculosis.—Menthol has decided analgesic properties, the patient

feeling marked relief for some time after each application.

The paintings decrease local inflammatory phenomena and disperse infiltrations.

They promote healing of superficial ulcers, but fail to induce cicatrization of deep ulcerations.

Strong solutions (forty and fifty per cent.) may cause local irritation. It is therefore better to begin with a ten per cent. solution and gradually increase the strength.

General treatment must always accompany the local applications in order to ensure success.—*The Four. of Laryngol. and Rhinol.*, May, 1890. C. H. K.

BOOK NOTICES.

Practical Electricity in Medicine and Surgery. By G. A. Liebig, Jr., Ph.D., Assistant in Electricity, Johns Hopkins University. etc., etc., and George H. Rohé, M.D., Professor of Obstetrics and Hygiene, College of Physicians and Surgeons, Baltimore, etc., etc. 8vo, pp. 383. Profusely illustrated. F. A. Davis, Philadelphia and London, 1890.

In the preface the authors says: "A treatise on medical electricity . . . to be of any value to the physician or the medical student, should be eminently practical, and should deal with such matters only as have a direct bearing upon the requirements of the practitioner. The book should be free from unnecessary technicalities, and only so much attention should be devoted to theory as is demanded in the explanation of such phenomena as are presented in the medical and surgical uses of electricity."

That they have not adhered very closely to their plan is evident from the fact that in a book of 383 pp. 142 pp. are devoted to electro-physics, and 28 pp. to the description of batteries, electrodes, etc.

Such an extended exposition of the physical side of the question, we claim, confuses more than it helps the average medical student. The bulk of the information contained in this chapter has its place in the average preliminary training of the student and should have been mastered then. We are ever at a loss to see why what is purely medical in electricity should occupy more space in a book on therapeutics than an article on digitalis or any other potent drug, or why it deserves the separate and sometimes bulky volume devoted to its study.

If separate treatises we must have, we claim that all that is essential on electro-physics and electro-physiology, and all that is established in electro-therapeutics could be well gotten in an 8vo volume of eighty pages.

If, on the other hand, one must set forth the refinements of electro-physics, advertise the goods of various instrument and battery makers, and lastly, collate *all* the *reputed* therapeutic applications of electricity, showing no discrimination or selection in the same, then a big book is needed, and that is what we generally get.

In this book, as in many others of its class, the pages are marred by the introduction of many unscientific and unsubstantiated recommendations.

Taking the entirely uncorroborated statement of Dr. A. or Prof. B. that this or that current is curative in this or that disease, more than any thing else fills our books with lumber and throws the would-be practical reader off the scent of what the real indications for the remedy are.

As an example of the loose way in which electricity is prescribed the following quotation concerning angina pectoris will suffice.

"*Angina pectoris*. During the attacks cutaneous faradization with the dry brush over the cardiac region, as recommended by Duchenne, may be tried. This method cuts short the attack. Direct faradization of the cardiac region, using large, moist electrodes and strong currents from spine to front of thorax, has also been successfully employed. Eulenberg uses galvanism, cathode to the spine, anode over the heart. Sub-aural and vagus galvanization and galvanization of the cervical portion of the cord should be persistently followed up during the intervals. Static electricity has also been used with success in the forms of static breeze and insulation."

The best physiologists for some time have taught that electrization of the heart, directly, *i.e.*, through the chest walls or indirectly, *i.e.*, through the nerves in the neck, is a procedure fraught with danger when thorough and devoid of effect when conducted within the bounds of safety.

Criticisms of such, what we think, fallacious teaching, apply not only to the book in hand but to almost all so-called text-books on electro-therapeutics. R. W. A.

Electricity in the Diseases of Women, with Special Reference to the Application of Strong Currents. By G. Betton Massey, M.D., etc. Second edition revised and enlarged. 12mo, pp. 240. F. A. Davis, Philadelphia and London, 1890.

The exhaustion of the first edition of this book in thirteen months speaks wells for its popularity. Many new electro-therapeutic contributions to gynecology are added, and also new chapters on subinvolution and chronic inflammatory diseases of the appendages. Graphic representations of the law of Ohm and of the laws of current diffusion have been added to the appendix.

The Suppression of Consumption. By G. W. Hambleton, M.D., President of the Polytechnic Physical Development Society of Great Britain. 12mo, pp. 37. N. D. C. Hodges, 47 Lafayette Place, N. Y., 1890.

The author believes in the possibility of eradicating consumption. Leading up to his theory on this subject he advances his ideas as to the etiology of the disease. He discards as untenable the idea that climate, impure air, insufficient clothing, other pulmonary diseases, dyspepsia, inheritance, or even the *bacillus tuberculosis* have much, if any thing, to do with the production of consumption. His idea is that the disease is produced by almost any conditions which tend to reduce the breathing capacity. Confinement or occupations which compress the thorax or impede the respiratory functions and dust-inhaling trades notoriously produce consumption. It is, then, a disease of civilization, and is best prevented or stopped by the adoption of measures tending to compensate or counteract the above-mentioned conditions.

THE MEDICAL ANALECTIC AND EPITOME.

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE.

EDITED BY R. W. AMIDON, M.D.

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THERAPEUTICS.

Shaw (T. C.) and Cripps (H.) on the Surgical Treatment of General Paralysis.—These authors report another case of general paresis, in which temporary improvement followed trephining. A male of twenty-nine had well-marked symptoms of general paresis following fifteen months after a blow on the left side of the head.

Two buttons of bone were removed with a one-inch trephine from the left parietal eminence and the subjacent dura, arachnoid, and pia removed. Healing was complete in a few days, and considerable improvement ensued. The pain in the head had entirely disappeared, and his memory was much better. There was no trace of delusion beyond a certain amount of contentment and sense of well-being. The motor symptoms appeared to be stationary. After being out on trial for a month in the care of his wife, he was discharged on April 18th, there being no mental disease beyond a little dulness to be observed, apart that is from the motor impairment. It is to be remarked that no convulsions have at any time been noticed either before or since operation, but, as is well known, this symptom is often deferred until a late stage of the disease.

On May 14th, in answer to inquiry, it would appear that though the railway company gave him a situation as ticket collector, he has not been able to retain it. He appears to be suffering from some intestinal complication, and is also irritable, whence it would seem that he is in much the same state as when he left the asylum.

There is no doubt that some of the painful, urgent symptoms were removed, and that the mental state as regards memory was much better, but the motor symptoms appear not to have been relieved. It must be remembered that the symptoms were well advanced before operation was resorted to, and that so far did his insanity disappear that he became responsible, and might safely have been permitted to make a will. In fact, a certificate of insanity could not have been made out against him.

The case[1] in which the authors' first operation was performed has just died, and its subsequent history and post-mortem findings are subjoined:

The man was trephined last July, when in a very advanced state of disease. This patient, it will be remembered, before the operation often had convulsive seizures, chiefly on the left side. After the operation he went on very favorably until September 18th, when he had an attack of faintness with slight numbness of the left hand, which however soon passed off. From this time his mental condition improved greatly; he was cheerful and able to read several hours consecutively, his memory improved, and he had no recurrence of the convulsive attacks. The motor symptoms did not improve. So well did the patient become that from the disappearance of the mental symptoms it became impossible to keep him under certificates, and his discharge to the workhouse was ordered, when on February 14th he had a strong attack of convulsions, and after lying in a comatose state some time, he died on February 20, 1890, six months after operation.

It was noticed that during this last convulsive attack, though there was a little

[1] MEDICAL ANALECTIC, Dec. 12, 1889, p. 589.

pulsation, there was no bulging over the trephine hole, and this led us to suppose that no benefit would be obtained by opening up the scar. The absence of bulging was accounted for at the post-mortem examination, and there is no doubt that it would have been good practice to have again operated. At the post-mortem examination, the place of the removed bone was found to be filled with a very dense fibrous membrane (which doubtless prevented any bulging), and about six ounces of fluid were obtained from the brain. The under surface of the above-mentioned fibrous membrane was found adherent to the cortex in the middle of the ascending frontal convolution. The mitral valve was thickened, and this may have accounted for the fainting attack already noted.

Whether the fluid found in the brain in general paralysis is primary or compensatory is a question of some interest and importance. There can be no doubt that in both the cases operated upon, the fluid was exercising considerable pressure, as evinced by the marked bulging of the dura mater. Had it been purely compensatory, such intercranial pressure could not have been present. By relieving this pressure, if a cure cannot be obtained, there is great relief, as shown by our reported cases and by that of Dr. Batty Tuke. The cases are too few at present to judge of the risks of the operation, but if as a result a patient improve so much as to be able to make a will (and either of these patients might have been allowed to do this) there can be little question about the operation being considered a success. It must at the same time be owned that some improvement in the time when the operation may be best performed, together with a better knowledge of the size the opening should be made, is possible. Indeed, it would appear from what was subsequently observed in the first case, there would be a better chance of permanently relieving pressure by removing a much larger area, both of the bone and meninges, than we have hitherto done.—*Brit. Med. Jour.*, June 14, 1890.

Porcher (F. P.) on Phenacetine in Insomnia.—I desire to call special attention to the extreme value of phenacetine as a remedy for insomnia. Given at night in a little water it is tasteless, innocuous, and induces sleep. I am confident, also, after repeated trials, that it is the best and most unobjectionable substitute for morphia. It causes sleep when, of course, pain is in abeyance, unless the pain be more than ordinary, and morphia hypodermically may then be required. The remedy may be repeated and the dose increased to seven or ten grains.

Suffering from chronic rheumatism of the forearm, I have tested it repeatedly in my own person, and have given it to many who have suffered from insomnia, or inability to sleep from any transient cause, fatigue, nervousness, excitement, etc., in either sex.

I see that sulphonal has recently been advised. No accusations have ever been made against phenacetine, whereas, sulphonal, antipyrine, and antifebrine have at times been found to possess toxic qualities.

I have made comparative tests of the four agents, and believe that phenacetine has a great future for the two purposes above indicated. It may also be used in children who are sleepless from fever or excitement.—*Med. Rec.*, July 12, 1890.

Kinnier (D. F.) on Chloralamide as an Hypnotic in the Treatment of Mental Diseases.—The author reports fifteen cases of mental disease in which he has employed chloralamide with more or less benefit. The patients had various forms of mania, dementia, and melancholia. The indication for the drug was insomnia. According to the author the hypnotic effect of the drug seemed in many instances to be too slowly produced, especially in maniacal cases characterized by much violence. When produced in these cases the sleep was generally restless. In some cases of melancholia the drug seemed to act well and in a short time, but the author does not think its hypnotic effects are rapid enough to warrant its use in cases of acute delirious mania or in cases of great excitement where sleep is urgently required.

If given in large doses, 60 grs. for instance, there is no doubt sleep will result in twenty or thirty minutes, but such large doses are apt to produce vomiting, vertigo, and other disagreeable symptoms. Much smaller commencing doses are advisable. —*Med. Rec.*, July 12, 1890.

Physiological Effects of Chloralamide.—Dr. Malakhovski, in order to study the physiological action of chloralamide, has made an elaborate series of experiments on more than sixty frogs, dogs, and rabbits. He finds that chloralamide is

only poisonous to frogs when given in very large doses. It disorders the co-ordinating apparatus after having first diminished the reflexes; it diminishes the tendency to movement, producing a condition of quiescence; it first slows and ultimately paralyzes the respiratory movements. The heart's contractions appear at first to be strengthened, but cardiac paralysis is ultimately produced. In warm-blooded animals—dogs and rabbits—sleep is induced by action on the brain, the irritability of both brain and spinal cord being diminished. As in frogs, there is interference with the co-ordinating apparatus, and this is due to action on the central nervous system. The reflexes are diminished from action on the reflex centres situated in the spinal cord. The blood pressure is lowered from a paralyzing action on the vasomotor centre. The heart's beats become more rapid from action on the central cardiac inhibitory apparatus. The irritability of the respiratory centre is increased. The temperature is lowered both because of diminished loss of heat from the surface of the body and because of a decrease in the generation of heat. In the case of dogs the gastro-intestinal system was affected.—*Lancet*, July 5, 1890.

Bury (J. S.) on the Treatment of Epilepsy by Biborate of Soda.—A girl aged six years had been subject to fits for a few weeks, which the mother attributed to a fall on the head. The child attended as an out-patient for some time; but as the fits appeared to be uninfluenced by the administration of bromide of potassium, she was taken into the hospital, in order that the effects of treatment might be more accurately observed. During the first five days she took every four hours a mixture containing five grains of bromide of potassium and five minims of tincture of belladonna; but on each day she had from twelve to twenty attacks of general convulsions with loss of consciousness. The doses of bromide and belladonna were then increased to ten grains and seven minims respectively; but as the frequency of the fits remained unaltered, she was ordered to take five grains of boric acid in water every four hours. During the next four days the number of fits fell to nine and ten daily, and when the dose of boric acid was increased to ten grains the improvement was still more marked; the fits ceased on the fifth day, and the child subsequently left the hospital completely cured. Since that time I have repeatedly prescribed boracic acid and borax, both for ordinary epilepsy and for the convulsions associated with the spastic hemiplegia of infancy, and as a rule with good results.—*Lancet*, May 31, 1890.

Bassette (M. I.) on the Action of Gelsemium in Some Local Spasms and Neuralgias.—This article is chiefly interesting because of the large amount of the drug taken. Well marked physiological but no toxic effects were produced.

The patient was a woman in whom a clonic spasm of the muscles supplied by the spinal accessory nerve followed a fall from a wagon.

For three weeks, from January 31st to February 21st, this patient took for the greater part of the time twenty-six drops or thirteen minims every two hours night and day. For another part of this time, alternately, either thirteen minims, or seven and a half minims every two hours, or about this amount. For the remaining forty-seven days she took about thirteen minims eight times daily. The average taken daily, when the maximum amount was administered, was about one hundred and fifty-six minims. During three weeks, from January 31st to February 21st, she probably took between five and six ounces, and during the last forty-seven days in all 4,888 minims, equal to eighty-one ounces.

Very marked improvement but no complete cure resulted.—*Jour. Nerv. and Ment. Disease*, June, 1890.

Chadbourne (A. P.) on a Case of Diabetic Coma, Treated by Intravenous Injection of Saline Solution; Death.—The patient was a shoemaker of twenty-one, passing 5 to 6 quarts of water containing 3.5 % of sugar.

Toward night, April 16th, the stupor increased to deep coma, the pulse grew weaker, and whiskey was given several times by mouth, also muriate of cocaine, gr. ¼. There was frequent involuntary micturition, the urine being acid to litmus paper.

At 10.30 P.M., the pulse could not be felt at the wrist, the cardiac pulsation was 160, intermitting, respiration was slow and stertorous, the papillary reaction absent, and there was slight cyanosis. I opened the left median cephalic vein and in five minutes allowed 30 ℥ of a 5 % aqueous solution of sodium bicarbonate to flow in. The pulse gradually improved, and one

hour later was 120 at the wrist, full and regular; respiration quiet and regular; the patient perfectly rational. He talked with his mother for some time, then turned on his side and slept naturally. Involuntary micturition ceased, but, owing to a misunderstanding, no urine was kept for examination.

April 17th. At 5 A.M., the patient was somewhat restless, and at times mildly delirious, though he could be aroused to answer questions. Micturition was again involuntary. At 9 A.M., the deep coma had returned, and the condition was the same as the night before, no pulse at the wrist, at the cardiac apex 150, intermitting.

Dr. Shattuck saw the patient for the first time since the morning of April 16th, and ordered the injection repeated. In ten minutes 32 ℥ of a 5 % solution of sodium bicarbonate was injected; the pulse immediately improved, and one hour later had fallen to 128, and was of fair strength and regular; the patient was again rational, though somewhat dazed. Involuntary micturition continued, urine acid. About noon coma came on rapidly. The friends refused to have the injection tried again, and the patient died in less than an hour.

The author gives abstracts of 17 cases of diabetic coma in which subcutaneous or intravenous injections were employed with the following results. In only one was the operation completely successful, the patient having left the hospital two months later; in seven the patients were rational for a longer or shorter time, and were able to speak and answer questions; one could swallow but was unable to speak; of one it is only stated that the mental condition improved, while in a third there was improvement, and inferentially the patient could speak and answer questions. In four cases there was not even temporary improvement, and in three the gain was very slight.

In 53 % of the cases then there was a gain that ought to be of great value to both patient and friends, though in only 6.6 % (one case) was the gain permanent.

The author thinks we can say that intravenous injection will be likely to give the patient a few hours of complete consciousness, with the possibility of recovery from this almost hopeless condition, and that the chance of a favorable result is probably better if the operation is done as soon as the first signs of coma have been surely recognized.—*Boston Med. and Surg. Jour.*, June 26, 1890.

Rice (R.) on Venesection in Puerperal Eclampsia.—M. B., aged twenty-nine, was confined of a living male child in the evening of June 26th; she was attended by a midwife, and every thing passed off normally. I was summoned to her at 3 A.M. the following morning, as she felt in very great pain all over. On my arrival, I found she was suffering from flatulence, accompanied by nausea and pain in the stomach. I administered a carminative and calomel 5 grains. I saw her at 9.30 the same morning, and found that convulsions had commenced at 6 A.M., that these had occurred every twenty minutes, and lasted some three minutes. She was a stout, muscular, florid, full-blooded woman, and when I saw her was unconscious, foaming at the mouth, very restless, and continually throwing herself about, vomiting freely green-stained mucus, with a pulse of 100°. I at once injected a quarter of a grain of pilocarpin, and waited a quarter of an hour. Another violent convulsion then occurred. As it was impossible to administer any thing by the mouth on account of the vomiting, and having no chloroform with me, I bled her from the arm to twelve ounces. The effect was immediate; the patient became quiet, the vomiting to a great extent ceased, and she lay quietly in bed. I then left her, and returned in four hours' time to find that she was much quieter, more conscious, and that she had only been convulsed three times since the bleeding, and at greater intervals. She shortly after regained perfect consciousness, desired to be changed, and passed a good night, but was perfectly oblivious of all that she had passed through. I examined the first specimen of her urine that I could obtain, but found no albumen. I may say that when able to swallow, I gave every four hours a mixture containing 20-grain doses of chloral and 30 grains of bromide.—*Lancet*, June 7, 1890.

Marshall (C. F.) and Semple (A.) on a Case of Chorea Treated by Arsenic Followed by Paralysis and Pigmentation of the Skin.—Charles J——, aged six, was admitted on January 11, 1890, suffering from chorea. The movements were rather violent, and affected the limbs and face equally on both sides. There were no rheumatic or cardiac complications, excepting a slight systolic

murmur, which developed after admission. There was a history of rheumatism in the father. The patient was treated with liquor arsenicalis, beginning with three minims, gradually increased to ten minims three times a day. In about two weeks the choreic movements were much diminished.

On February 13th (after taking arsenic for about four weeks) the temperature, which had previously been normal, rose to 101°, and slight malaise and anorexia were complained of. The drug was then stopped, and the symptoms abated. A few days later there was weakness in the right arm and in both legs. None of the ordinary toxic effects of arsenic were observed. Hence the drug was resumed on the 26th, four minims three times a day. A few days later dark-brown pigmentation of the skin was noticed in the axillæ, back of the neck, and in the popliteal spaces; this rapidly increased till the whole body was pigmented, with the exception of the face, the complexion of the latter becoming at the same time of a pink and white color. As the pigmentation was presumably due to the arsenic, this was again left off. At this time there was marked paralysis of both legs, chiefly affecting the extensors of the feet and toes; the knee-jerks were absent, and the reaction of degeneration was well marked, the extensor muscles not responding at all to the faradaic current, but responding well to the galvanic. There was also marked wasting of the legs; the upper limbs were scarcely at all affected, slight weakness of the right arm being all that was observed. There was no paralysis of any other part. The patient was treated with small doses of iodide of potassium, and massage was employed.

When examined on April 28th, the pigmentation had mostly disappeared, and the paralysis was much diminished. The reaction of degeneration was also less marked, the muscles reacting slightly to the faradaic current. The gait was at this time that of peripheral neuritis, the toes being dropped and catching against the ground, while the heels were abnormally raised; whereas on March 26th the gait was more like that of locomotor ataxy, the legs being raised and thrown out with marked inco-ordination, and there was much difficulty in turning round.—*Lancet*, June 14, 1890.

Dunlop (J. C.) on Deafness Treated by Pilocarpin.—J. C., aged thirteen, has always had very imperfect hearing; when five years old was tested by Dr. McBride, and found able to hear a watch at only three inches from both ears. In January, of the present year, he had a very severe attack of measles, and after recovering from this was found to hear worse than before, namely, he could only hear a watch at 1½ inch. By means of Politzering this distance was increased to 3½ inches.

On March 13th he was taken to see Dr. McBride, and at his suggestion pilocarpin was injected daily, commencing on March 15th. The distances on the respective days being:

	Right.	Left.
March 15th ...	2½ inches ...	3½ inches
" 18th ...	5½ " ...	5½ "
" 21st ...	9½ " ...	7½ "
" 24th ...	10 " ...	8½ "
" 27th ...	16 " ...	16½ "
" 30th ...	28 " ...	30 "
April 2d ...	44 " ...	46 "
" 5th ...	48 " ...	48 "

The last injection was made on April 5th, there being in all twenty-one injections. The dose at first was one-twelfth grain, but this was soon increased to one-sixth, and later to one-fifth grain.

After stopping the treatment I examined daily for five days, the distance remaining the same. A month after this I again examined, and found them not only to have maintained the improvement, but to be slightly better—50 inches from both ears. The power of hearing conversation is also very markedly improved, but not to the same striking extent to which his power of hearing a watch is.

The case is probably one of mixed middle- and internal-ear deafness, the bone-conduction being much diminished. There were no unpleasant symptoms arising from the treatment.—*Brit. Med. Jour.*, June 7, 1890.

Christy (T.) on the Kola Nut as a Food and Medicine.—The kola nut is held in great respect by the natives of the western coast of Africa, on account of its wonderful stimulating and sustaining powers; the nut is ground into a fine powder and carried about the person during long journeys, when often the only sustenance consists of a "chew" of this kola; thanks to it many have been able to stave off thirst and hunger, while others declare that, after a severe day's work or marching, nothing so revives the system as a kola nut. As a basis for a beverage, the

analysis published comparing the nitrogenous principles, chemically defined and crystallizable, kola takes precedence over tea, coffee, and cocoa, while owing to the almost entire absence of tannin in it, it does not injure or impair the digestive organs. The stimulating tonic and sustaining powers of kola are mostly due to the caffeine, of which it contains over 2½ per cent., and sufferers from indigestion, nervous or bilious headaches will hail with satisfaction a beverage which they can drink as a substitute for tea, coffee, or cocoa. From the accounts given, kola is likely to prove not only a great rival to tea and coffee, but also a drug substituting the ordinary run of tonics and stimulants. Planters in the tropics having low-lying marshy lands will find the kola tree a profitable product, yielding as it does, at full maturity, about 1 cwt. of nuts per annum. The flowering and fruiting takes place simultaneously twice a year, so that there is presented the curious sight of a tree bearing fruit and flower at the same moment.—*Hospital Gazette*, April 26, 1890.

Gluck (I.) on the Prevention of the Toxic Effect of Cocaine.—For the reasons above mentioned I was led into a series of experiments with a view to rid cocaine of these defects, the result being the discovery that cocaine in combination with phenol not only removes the objectionable features, but increases its usefulness. The formula which I have adopted is the following:

℞ Phenol..... gtt. ij.
Distilled water..... ʒ j.
Shake until solution is perfect, then add
cocaine hydrochlorate, gr. [illegible].

I have been using the above formula for over a year, and since using it have never had to deal with the toxic effect of the drug. In fact, I have been able to use it in any quantity, and in any part of the nose or throat, without the least fear of harmful consequences. Phenol, in the same manner as cocaine, by suspending the functions of the sensory nerves, is itself a local anæsthetic of no mean power. The combined action intensifies the anæsthetic. Phenol also coagulates albumen and combines with fats, forming a very superficial eschar which prevents the absorption of cocaine, and hence its toxic effect. Phenol is also destructive of bacteria, fungi, etc., and prevents decomposition in the solution. Its effect is also to ward off the congestive and other reactive effects experienced after the use of cocaine, which, next to chloroform and opium, is nature's greatest boon to mankind.

Résumé: The Advantages of Phenol and Cocaine.—1. Prevents toxic effects; 2. increases the anæsthetic effect; 3. prevents congestive reaction; 4. prevents decomposition of the solution; 5. renders solution aseptic.—*Med. Record*, June 21, 1890.

Shively (H. L.), Attempted Suicide by Hydrocyanic Acid Poisoning; Recovery after the Ingestion of Half an Ounce of the Officinal Solution.—A student of pharmacy, æt. twenty-two, was found unconscious about four o'clock in the afternoon of April 12th. When first seen he was half sitting, half reclining, on a bench, with his head extended over its back, with eyes upturned and limbs relaxed. He had vomited about a teaspoonful of greenish material. Efforts to arouse him were unsuccessful. He was removed to the Presbyterian Hospital, and as he was lifted into the ambulance a slight clonic convulsion was observed.

On admission the patient was unconscious, pupils widely dilated, the right a little more so than the left; pulse 86, small and compressible; respiration shallow, sighing, and ranging between forty and fifty a minute. There was conjugate deviation of optic axis outward. There was no cyanosis. The face, on the contrary, was of a warm, rosy tint, but the surface was cold; temperature *per rectum* 97½°. A faint odor resembling bitter almonds was detected in the patient's breath, which suggested prussic acid poisoning, and a search of the pockets was rewarded by finding a half-emptied, glass-stopped ounce vial of the officinal dilute hydrocyanic acid. The gastric siphon was passed, and the diagnosis further confirmed by testing the first washings, which were mixed with considerable partially digested food, and smelled strongly of prussic acid. On treating with solutions of ferrous chloride and ferric sulphate, and then with potassium carbonate, a characteristic precipitate of prussian blue was obtained.

At first the patient responded with slight movements when pinched, but the coma soon deepened into complete insensibility with abolition of reflexes. The pulse rapidly ran up to 112, and became thready and irregular in force and frequency. The

impulse of the apex beat was expansile and vibratory; the heart's action was labored and tumultuous. The patient breathed badly, and death appeared impending. Although the dyspnœa was extreme, there was no pallor of the mucous membranes or lividity, the color continuing of the same bright arterial hue throughout. There was decided trismus, rendering the introduction of the stomach-tube difficult, and for a brief space there was rigidity of the limbs. At the same time involuntary escape of the urine was noted.

Lavage of the stomach was persisted in until the washings were perfectly clear and the odor of the poison could no longer be detected. From the first the patient was promptly stimulated hypodermatically with whiskey, camphorated ether, strychninæ sulphas gr. $\frac{1}{20}$ and atropinæ sulphas gr. $\frac{1}{60}$. *Per orem* he received in divided doses two ounces of whiskey and three drachms of aromatic spirits of ammonia in hot water. A stimulating enema of three ounces of whiskey and two ounces of hot water was administered. Dry heat was applied locally to the entire surface of the body and a hot-water bag was placed over the præcordium. Within twenty minutes the pulse, which had become alarmingly weak and irregular, began to revive, the impulses becoming fuller and stronger and their frequency diminishing. There was a corresponding improvement in the respirations and slight movements of the voluntary muscles could be elicited. The faradic current, which had been applied with one pole at the base of the neck over the situation of the pneumogastric and phrenic nerves, the other over the superficial cardiac area and epigastrum, appeared of benefit in maintaining both the heart and respiration. The patient manifested no sign of returning consciousness for two hours, but was out of danger within an hour after his admission.

Two ounces of pale, limpid urine, withdrawn by catheter, possessed the odor of the poison, and gave a well-marked blue precipitate with ferric and ferrous salts. The reaction was acid, specific gravity 1,017. Small, octahedral crystals of calcium oxalate were present. On applying heat and nitric acid twenty per cent. of albumen by bulk was thrown down. With Fehling's test for glucose a heavy, ochre precipitate was obtained.

On evening rounds at 7.30 P.M., the pulse was 108, respirations 28, temperature 98.5°. He had fully recovered and conversed freely. Family trouble and a morbid dread of failure in an approaching examination were the causes assigned for his act. He stated that his first sensation after swallowing the acid was a feeling of numbness and anæsthesia of the lips, quickly followed by shortness of breath and loss of consciousness. There was no feeling of constriction in the throat or burning sensation in the stomach. He experienced no nausea, and does not remember having vomited.

During the evening there were several loose fæcal movements, the first of which was streaked with blood. The urine passed during the night was amber in color; specific gravity 1,020, reaction acid. On testing, it no longer reacted with Fehling's solution, and the albumen was found reduced to three per cent. The reaction for prussic acid could not be obtained. Beside the albumen there were other evidences of a mild degree of acute, exudative nephritis in the presence of hyaline casts, leucocytes, and renal epithelium. The microscope showed numerous dumb-bell crystals of oxalate of calcium. The urine of the morning of the 14th was found perfectly normal. On the 13th and 14th patient had a temperature ranging between 99.8° and 100½°, and complained of weakness and want of appetite. On the 15th he was discharged cured.

In this case rather more than half an ounce of the fresh officinal solution was swallowed, an amount equivalent to four and eight-tenths grains of the anhydrous acid. This is double the quantity taken in the case reported by Burman (*Lancet*, January 14, 1854), which, up to the present time, has been quoted as the largest dose recovered from. Christison (*Edinburgh Monthly Journal*, February, 1850, page 97) reports a case of recovery after the ingestion of a grain and a half of the pure acid. These two are the largest recorded cases of recovery that I have found. Of interest as showing the smallness of the dose which is sometimes fatal, Garstang (*Lancet*, 1888, vol. ii., page 15) reports a case in which death followed a single dose of half a drachm of the two per cent. solution of the British Pharmacopœia. Woodman and Tidy report twenty-six cases, all but six of which were fatal. Of these the smallest lethal dose was nine-tenths of a grain.

In the case here reported, the strength of the acid was tested by experiment on kittens. Two drops of the portion remaining in the bottle found on the patient's person caused death in two and a half minutes when placed upon the tongue of a healthy kitten. The animal emitted a few sharp cries and was seized with dyspnœa and clonic convulsions. Death was preceded by a brief tonic spasm and evacuation of urine and fæces.—*Am. Jour. Med. Sci.*, July, 1890.

Morphine as an Antidote to Atropine.—This case, reported in the *Med. Record* of Calcutta, is remarkable, and points triumphantly to the truth of the experimental deductions of those able therapeutists who have shown on physiological grounds that atropine poisoning can be counteracted by poisonous doses of morphine.

A medical student who was a great sufferer from neuralgia, for which he was accustomed to take antipyrin, went to indulge in his customary dose, but hit upon the wrong bottle and took four grains of atropine instead of antipyrin. In a few moments he became unconscious and fell. He was seen by a brother medical student, who instantly ran off and called Dr. Lawrie. An emetic was speedily given, and the stomach-pump used to wash out the contents of the stomach. The patient, however, seemed to be rapidly sinking from the profound narcotism of the drug. The pupils were dilated to their fullest extent, there was foaming at the mouth, stertorous respiration, and a rapid intermitting pulse. The patient's condition seemed hastening towards the end, when Dr. Lawrie thought he would resort to the antagonistic effects of morphine, and quickly injected one grain of this drug subcutaneously with no apparent effect. He then injected another grain, but with no decided result. The patient, though still alive, seemed hovering in the balance between life and death. From eight o'clock in the morning till three in the evening artificial respiration was resorted to with varying intervals of rest. Dr. Lawrie now determined to try the hypodermic injection of a third grain of morphine, and this seemed to be the determining antidote, for in an hour the pulse improved, the breathing gradually resumed its normal standard, and consciousness returned.—*Brit. Med. Jour.*, June 21, 1890.

Goss (C. W.) on Nitro-glycerin in Gas Poisoning.—A plumber, forty years old, was tapping a gas main in a close cellar, when the pipe suddenly broke and he was overcome before he could get out. When I saw him he was cyanotic, respiration spasmodic and very shallow. There was an entire absence of pulse at the wrist, his extremities were cold, and a state of profound unconsciousness existed. Nitro-glycerin was administered in one one-hundredth grain doses, at intervals of ten minutes, hypodermically. In thirty seconds from the time of the first injection the pulse was noticeable at the wrist, and grew steadily stronger. At the end of fifty minutes the patient was conscious and said he felt right well, with the exception of a a numbness in the extremities. From this time on he grew rapidly better, and at the end of three hours was able to walk home. Artificial respiration was not used at all, but it was observed that as the volume of the pulse increased the embarrassment of respiration was proportionately relieved. The prime indication in this class of cases is to establish the equilibrium of the heart and let respiration take care of itself.—*N. Y. Med. Jour.*, June 14, 1890.

Kolipinski (L.) on Nitro-glycerin Poisoning.—The patient was a woman of twenty-nine, a sufferer from cardiac asthma. When I first saw her she had been taking a mixture which had produced symptoms of mild belladonna poisoning. The action of the heart was then feeble and irregular, and I prescribed drop doses of a one-per-cent. solution of nitro-glycerin; also a solution of morphine, not only to produce sleep, but as an antidote to the belladonna. Early on the following morning she arose to take a dose of the morphine solution, but by mistake swallowed two drachms of nitro-glycerin. She soon remarked that the medicine "affected her head like brandy."

I was sent for, and on arrival found her with cold extremities and pale face; pulse strong and regular—eighty beats to the minute. She was semi-conscious, and the asthmatic breathing of the previous evening was still present. She apparently suffered from gastric distress, and subsequently told me that she had a desire to vomit.

A hot mustard foot-bath was given, and an emetic of mustard in coffee was administered, which was quickly followed by vom-

iting. As her condition was no longer alarming I left, with directions that her chest should be enveloped in a flaxseed poultice and that she remain in bed. On my return, later in the day, the dyspnœa had markedly subsided, and she had nearly recovered from her distressing symptoms.

After recovery she told me that she imperfectly recollected the events following the dose of nitro-glycerin, though she remembered that breathing was more difficult than usual and that she was nauseated. —*Med. News*, May 17, 1890.

Auld (A. G.) on Collapse Following the Internal Administration of Salicylate of Sodium.—J. M—— had been under treatment for subacute rheumatism for six months in another part of the country without deriving any benefit. On May 1, 1889, I prescribed for her 100 grains daily of salicylate of sodium. On the 4th she complained of giddiness, confusion of ideas, and weakness. On the 5th the giddiness was excessive and the patient was unable to get out of bed. The next day, having now taken 600 grains, there were delirium and prostration. The drug was now stopped, and when the patient regained her faculties the joint symptoms had disappeared, and did not return.

H. C—— had for years suffered from articular rheumatism, chiefly in the lower extremities. On May 24, 1889, I prescribed 100 grains daily of the salicylate of sodium, which was supplied by the same chemists as in the previous case. On May 30th I was summoned at midnight to the patient, who was said to be dying. Briefly stated, his symptoms were great and stridulous dyspnœa, extreme slowness of the pulse, and general paralysis, the patient being unable to speak. Delirium was not so marked, however, as in the other case. After appropriate treatment he recovered and his malady was considerably relieved for a time.—*Lancet*, June 14, 1890.

Reedy (W. H.) on Salol in Lymphangitis.—A man of fifty-four acquired a lymphangitis of the entire upper left quarter of the body through a slight break of the skin on the back of the left thumb. Multiple large abscesses and blood poisoning ensued. All other drugs being stopped, six fifteen-grain doses of salol were given each day for a week. In thirty-six hours after beginning it there was a very noticeable diminution in the amount of pus, with less fever and sweating. Improvement was regular and constant during a week, and by the end of it the discharge of pus was almost stopped and the general outlook for the patient was greatly improved. At this juncture the salol was withdrawn entirely and iron and quinine were given for a week, with the result of suppuration increasing regularly with higher temperature and more sweating. At the end of a week salol was again substituted in free doses, and in twenty-four hours the suppuration had almost ceased and improvement was rapid and regular to complete recovery. It appeared that salol controlled suppuration. Salol was continued in decreasing doses for nearly two months. To-day the patient is apparently as well as ever, with the exception of impaired motion of the left shoulder joint from abscess of joint resulting in contractions and adhesions. Since the foregoing case the author has used salol in one other case of lymphangitis in an early stage, and the attack was apparently aborted; also in several cases of erysipelas where the disease was more promptly controlled than by any other plan of treatment that he is aware of. He always gives the dry powder in the mouth and washes it down with water, and never gave it where it caused any disagreeable symptoms or was not well tolerated by the stomach, and has given over half an ounce a day to an adult. He attributes others' failure with the drug in many instances to using it too sparingly.—*N. Y. Med. Jour.*, June 14, 1890.

Armstrong (S. T.) on a Case of Acetanilide Poisoning.—A healthy young seaman, aged 28, had been treated for hypertrophy of inguinal glands by extirpation. On November 25th he complained of pains in various portions of the body; and, as these increased in severity,—notwithstanding the fact that he was on anti-syphilitic treatment,—on the morning of the 26th a prescription was written for antifebrin, 3ii, divided into eight powders, with directions that one powder should be taken every half hour until the headache, that was especially severe, ceased. While this was a careless way to write a prescription for this drug, it was expected that one, or, at least, two powders would afford relief; and eight powders were ordered because it was surmised that they would have to be continued daily until the specific action of the anti-syphilitic medicine was obtained.

The nurse faithfully followed the direc-

tions, and, as the headache did not cease, the powders were given until eight o'clock, when the last was taken. At this time he was seen at the evening visit of the externe; the patient's skin was cold and blue; there were general symptoms of collapse; he had vomited freely; and in attempting to rise from his bed, fell to the floor unconscious. There was but slight muscular control; the heart's action was very rapid, but the pulse was not taken. Hot bottles were applied to the feet and legs, and whiskey was given by the mouth during the night. He did not sleep during the night, and the nausea continued until the next morning.

At the time of my ward visit, on the morning of the 27th, the patient felt very weak, the skin was moist, temperature 100.2° F., and pulse 130, compressible; his respiration was normal; the lips were still cyanosed, and the skin had a corpse-like appearance. His urine was normal. Milk-punch was given during the day, and by evening the patient felt as well as usual.—*Therap. Gaz.*, Apr. 15, 1890.

Taylor (W. H.) on the Toxic Effect of Acetanilide.—A woman of twenty-six was delivered July 13th of a well developed child, after a labor of two hours, after which the woman was in satisfactory condition until the evening of the third day after delivery, July 17th, when suddenly she developed severe pain in the head, back and abdomen, with vertigo and slight dyspnœa; urine normal in amount, but contained a large amount of albumen; lochia scant, but not offensive: 5 p.m. pulse 96, temperature 103.5°; gave acetanilide, gr. 5; 7 p.m. pulse 88, temperature 102.8°, repeated acetanilide, gr. 5; 10 p.m. found the patient in a profuse clammy perspiration, cyanosed, with pinched features; complained of pain in head and epigastrium, and weakness; pulse 68, temperature 95°; ordered heat to surface, and whiskey freely.

July 18th, pulse 72, temperature 96°; cyanosed, and complains of headache and pain in back.

During the ensuing eight days the patient improved in her general condition, but her temperature never rose above 98.2°, and on several occasions it was only 97°.

My colleague, Prof. J. Eichberg, kindly gave me notes of a case:

Female, aged nineteen, six months advanced in pregnancy; for ten days before admission to hospital had had diarrhœa, backache, malaise, epistaxis; the temperature the morning of admission was 99.3°; in the evening it reached 103.8°, and ten grs. of acetanilide was given. The temperature was taken at frequent intervals during the night, and declined to 95°, pulse 120, skin cool and moist; although slightly cyanosed, there was not much apparent prostration. Whiskey was given, and in a few hours the temperature was above normal.—*Cincinnati Lancet-Clinic*, June 7, 1890.

Vickery (H. F.) on the Treatment of Chronic Diarrhœa.—To give the diseased parts rest, the author gives meat broths and sterilized milk, in small amounts five or six times a day.

To check abnormal fermentation he has employed in different cases subnitrate of bismuth, carbolic acid (gr. ss. dose). Beta naphthol (gr. ss. to i.), salol (gr. ii. ss. to v), or thymol (gr. ii.) He does not express his preferences.

He prevents fæcal accumulation by cool enemata and perhaps occasional doses of rhubarb or cascara.

Pain can be mitigated by rest in bed, by a flannel abdominal bandage or in bad cases by opium.

When bloody or mucous dejections pointing to a colitis occur, a rectal injection, with a long soft tube, of two or three pints of cold water, containing sulphate of zinc or alum (gr. i. to ʒ iv. or vi.) or nitrate of silver (gr. ii. to O), can be made every day or two and allowed to come away at once.—*Boston Med. and Surg. Jour.*, Feb. 20, 1890.

Sänger on the Abuse of Purgatives.—Professor Sänger said that the abuse of these drugs caused, not habitual constipation, but rather "artificial constipation." The evil was most prevalent amongst women with chronic pelvic diseases, real or imaginary. He ordered, in such cases, that all purgatives be discontinued. He never had bad results, even when constipation lasted for over a week. Belladonna was the only drug he ever used when flatulence, etc., set in, and when the constipation lasted for very long. He objected to dieting, which kept up a pernicious feeling of invalidism, and, finding that the patients drank little water, he made them take several glasses of filtered water daily, when fasting; occasionally whey or buttermilk was given as a change. Fruit, brown bread, and exercise were recommended. Professor Sänger found this treat-

ment far better than massage, visits to watering-places, enemata, and other familiar means to the same end. In the long run his patients had natural actions of the bowels, and were cured of their invalidism. —*Brit. Med. Jour.*, June 7, 1890.

Orexin; the New Tonic.—Dr. F. Penzoldt, in the *Therapeutische Monatshefte*, describes the muriate of phenyl-hydrochinazolin or orexin (ὄρεξις, appetite) as a remedy which improves all the functions of the stomach, and especially increases the appetite. The drug, which is easily soluble in water, has a bitter, burning taste. It is a crystallized salt, and has only a very slight toxic effect in warm-blooded animals. The poisonous dose in man seems to begin at 25 grammes. In healthy persons slight disturbances, such as nausea, giddiness, or heat, only occurred after the use of one gramme *pro dosi*. After half a gramme there was a striking and rapid increase of appetite. In a healthy man one fourth of a gramme accelerated the digestion of white bread by half an hour, that of meat by thirty-eight minutes; half a gramme accelerated the digestion of meat by one hour. Experiments on thirty-six patients showed that in many cases the drug restored lost appetite. This effect rarely occurred after the first dose; usually it came on after several doses given in the course of a few days. Orexin has a prompt effect in anæmic and cachectic individuals, in patients on whom operations have been performed, in those suffering from phthisis, etc. The drug is of special value in commencing pulmonary tuberculosis, and Dr. Penzoldt in many such cases observed a considerable increase of the weight of the body. No disagreeable after-effects had been observed, except occasional burning along the œsophagus and rare and transitory vomiting. The dosage was from 0.3 to 0.5 gramme once or twice a day, and 0.5 gramme at once; the maximal daily dose is 1.5 grammes. Dr. Penzoldt recommends that orexin should be given in gelatinized pills with large quantities of fluid, owing to the irritating properties of the substance. The following is the formula: ℞ Orexin hydrochlor. 2.0 grammes; extr. gentian. pulv. radic. althææ q.s. ut fiant pilulæ xx; obduce gelatinâ. From three to five pills are ordered in the forenoon; later on this quantity is given twice a day, with a large cup of broth. The basis of orexin itself has a toxic effect like methylphenyl-chinazolin, and anisyldi-hydrochinazolin has little or no effect on the appetite.—*Brit. Med. Jour.*, June 28, 1890.

Ragsdale (A. C.) on Two Cases of Poisoning by Phytolacca Decandra.—Two children, aged six and eight years, were out playing and thought they had found some artichokes and partook freely of—poke-root.

When seen they were in great distress. Vomiting was incessant, and vomited matter almost pure blood. Temperature 95° F. Face and body covered with cold perspiration. Pulse 55 and very weak. Pupils dilated. Intense thirst. Complained of "being burnt up." Between paroxysms of vomiting were very drowsy and hard to arouse. Sense of constriction and soreness, with great dryness of mouth and throat. Constipation. From the amount of vomited matter, I judged that stomach had been completely evacuated. I therefore gave mucilaginous drinks (ulmus and egg.), stimulants and digitalis to keep up heart's action, and brisk cathartic to clear the intestinal canal.

The patients soon became quiet and I then left. Next morning word reached me that they were up and about and complaining only of a feeling of soreness in region of stomach and a dull headache. The children made a good recovery.—*St. Louis Clinique*, April, 1890.

Busey (S. C.) on the Oil-Silk Jacket in the Treatment of Bronchial Asthma.—The author claims that attacks of bronchial asthma which are ascribed to atmospheric conditions, and usually complicated, sooner or later, with more or less bronchial catarrh, can be prevented by the continuous wearing of an oil-silk jacket.

He cites three cases in which no asthmatic attacks occurred after the jacket was donned.—*Med. News*, April 19, 1890.

McCurdy (S. L.) on Turpentine as a Remedy in the Treatment of Membranous and Diphtheritic Croup.—The author has found it most convenient, after first thoroughly saturating the system with the drug, which will require about an ounce, in teaspoonful doses, to give three or four doses of a drachm every hour, night and morning, until convalescence was assured.

He is of the opinion that turpentine has a systemic action, as well as a local influence upon diphtheritic deposit. The local influence is shown by the membrane chan-

ging color on the exterior, and the constitutional effects are made manifest by the letting loose of the membrane from its attachment to the mucous membrane of the air-passage.

Drugs, locally applied, have heretofore had no influence upon the deposit, for the reason that, unless applied before it was sufficiently thick to be seen, it was too thick and dense to be penetrated. Hence the remedy failed to come in contact with the membrane-producing mucous surface.

A systemic drug that would destroy the growth of the deposit has not been known to the profession, while mercury in the form of calomel has been used with hope, but without much success.—*Columbus Medical Four.*, April, 1890.

Schenck (J.) on Catalpa Speciosa (WARDER).—The author employed, in his experiments, a tincture prepared by himself from the inner bark of the root and body of the tree. The maceration method was employed, an ounce of the bark making an ounce of the tincture. His experiments were on two healthy adults, and from them he deduced the following conclusions :

1. That with drachm-doses of the tincture, unless continued for a considerable time, the system is but slightly affected.

2. That if taken in large enough doses, it will slow the heart-beats, weaken its action, and finally produce an intermittent pulse.

3. That it acts on the alimentary secretions, producing a mild cholagogue, cathartic effect.

4. That in sufficiently large doses it produces nausea, and probably, in still larger doses, vomiting. It is probable that in this way it acts beneficially in asthma and bronchitis.

5. That by its sedative action on the heart it acts as an antipyretic.

In its clinical action he has found it most beneficial in those cases of pneumonia where the secretions of the alimentary canal are inactive and in which there is also a rapid and full pulse. It reduces the pulse-rate and tension, and increases the biliary secretion. Two drachms of the tincture should be given every one to three hours.

During the past winter he has used it often in cases of epidemic influenza with high fever, and especially where the inflammation extended into the frontal sinuses. In all of these acute cases he has never ventured to continue the remedy after the first two or three days, and has given it for this period only in sthenic cases.

Mr. E. O. Rau has made an imperfect chemical analysis of the seeds ; he obtained from them tannin and a bitter crystalline principle. Mr. F. K. Brown, by a more thorough analysis of the seed, found a resin, tannin, sugar, a fixed oil, and two undetermined crystalline bodies. It is reasonable to suspect that the medicinal qualities reside in the crystalline principles mentioned in the above analyses. It remains for chemists to tell us in which part of the plant they are most abundant, and, if possible, to isolate them, so that they may be used for further and more definite experiments.—*Med. News*, June 7, 1890.

Rusby (H. H.) on the Status of Pichi as a Remedy in Genito-Urinary Diseases.—In the treatment of acute cystitis following surgical operation, childbirth, gonorrhœa, or accompanied by acute congestion of the kidney, relief was prompt and strikingly marked, without any published exception except one. In such cases its action corresponds somewhat to a combination of henbane and buchu.

In the treatment of chronic cystitis relief was customary and a cure frequent, the results being probably as good as can be anticipated in chronic diseases, where a neglect of treatment or of its regularity is the almost invariable rule.

As an antilithic, its use very rarely resulted in disappointment. As a lithontriptic, it was the fortune of the remedy to meet with its chief reverses.

Notwithstanding the fact that pichi occurs freely in the urine, and is readily enough detected there by its strong odor, yet it must be in such a dilute condition as to produce such an effect as would be ruinous to the stomach and to the general health of the patient. What might be accomplished by urethral injections of a strong solution is not known. So far as I am aware, no experiments have been made in this direction. The failures, however, have resulted chiefly through an unintelligent method of trial. There is abundant evidence leading to the conviction that small calculi are very frequently dislodged and carried away as a result of free treatment with pichi ; and there is a prominent practitioner in Louisville who has quite a large vial filled with these small calculi,

which he claims to have removed by the aid of pichi alone.

The original statements concerning its effect in chronic Bright's disease now require to be accepted with some modification. Notwithstanding the fact that the amount of albumen is often increased, there are a number of cases in which unquestioned and great benefit has resulted in the treatment of this form of disease by pichi; and it is very possible that later and more scientific investigations will show us in just what class of cases of chronic Bright's disease it can be used with advantage.

In the treatment of hæmaturia, particularly, many fortunate results have been reached. At least half a dozen cases have come to my personal knowledge, where our most distinguished practitioners had failed in their application of the ordinary remedies, and in which complete relief was afforded by the administration of pichi. In one of these cases the patient, himself a prominent physician, had previously returned from treatment in Europe as the result of which all hope had been abandoned.

But little systematic attention also has been given to the effects of this drug upon the liver, and yet there is in the reports sufficient evidence to show that there are rich results in store for some practitioner who will patiently investigate its action in this direction. The treatment of dyspepsia and indigestion by this remedy is also an excellent field for clinical research.

One serious objection to the remedy had frequently been urged, namely, its very disagreeable savor; but this was happily overcome by the use of a solid extract encased in gelatine capsules. Another was its tendency to overset the stomach on continued administration; and this was overcome by pushing it for a few doses, and then ceasing the administration for a short time.—*Med. Record*, July 5, 1890.

Mahé (G.) on a Case of Chronic Vesical Catarrh Cured by Rapid Irrigation and Forcible Distension of the Bladder.—A man of twenty-seven had had gonorrhœa twice, resulting in a stricture which had been twice cut. A vesical catarrh at length appeared which resisted all ordinary treatment.

A large catheter, 25 F., with a Y-shaped double extremity was taken, and one leg of the Y was connected with a three-pint fountain syringe filled with hot bichloride solution (1:18,500). Introducing the catheter into the bladder and with the tip of the finger closing the orifice of the other leg of the Y, as much of the solution as the patient could bear was rapidly injected, thus fully distending the organ, especially the folds around the neck, and permitting the solution to penetrate between them and wash the mucus completely away. When the sense of discomfort became unbearable, the finger was removed from the orifice, the syringe cut off, and the bladder emptied with the same celerity as it had been filled. This process was repeated until three pints had been injected, removing the catheter at the last upon a full bladder, and allowing the patient to expel the solution through the urethra as in ordinary micturition.

The following prescription was ordered:

℞.—Pulvis cubebæ . . . . ʒ ii.
Pulvis acaciæ . . . . ʒ i.
Pulvis alum. . . . . ʒ i.
Bals. copaibæ . . . . ʒ iss.
Olei cinnamon. . . . . gtt. x.
Confectio. sennæ, s. q. . . . ʒ iv.—M.

SIG.—A piece as large as a hazel-nut three times a day, after meals.

After the first injection there was a profuse hemorrhage from the neck, which, however, was easily controlled. After the second irrigation (three days later) the hematuria was very slight, and at the third it had completely disappeared. This process was repeated ten times at regular intervals, when the patient had apparently entirely recovered; micturition was perfectly normal, and the mucus had completely disappeared. This result seemed to be due to the rapid and full distension of the bladder by irrigation, completely separating the folds around the neck, tearing away adhesions, the result of inflammation (producing the hemorrhage noticed), thus allowing the bichloride to thoroughly wash away the mucus from every portion of the organ, overcoming the over-sensitiveness of the neck, and allowing it to resume its normal degree of elasticity. Four points should be carefully borne in mind in using this treatment:

1. Injuries or diseases of the bladder walls which might result in perforation should always be carefully excluded.

2. It should not be used upon patients of such a nervous temperament as to suggest a possible disturbance of the innervation of the organ.

3. An exceedingly mild solution should be employed, increased according to individual tolerance.

4. Care should be taken not to introduce air into the bladder, as this may readily occur with a large catheter.—*Occidental Med. Times*, July, 1890.

De Schweinitz (G. E.) on the Treatment of Granular Lids with Strong Solutions of Bichloride of Mercury.—The method adopted has been as follows: Every alternate day the everted lids are carefully touched with a solution of bichloride of mercury, 1–300 or 1-120, according to the size of the granulations, while three times a day the conjunctival *cul-de-sac* is irrigated with a warm solution of the same drug, 1-7,000. No other medication is employed. The results have been almost uniformly favorable. In no single instance has the disease been aggravated; in a few it has apparently undergone no modification, while in the vast majority, after four or five applications of the character described, there has been increased comfort, lessening in the size of the granulations, dissipation of the discharge, and not infrequently amelioration of pannus, if this was present. Perhaps the strongest testimony in favor of this application is that given by most of the patients themselves, all of the chronic cases having, either in this institution or elsewhere, had all manner of local astringents applied to their everted lids. Their testimony is practically unanimous that this has given the greatest comfort. It is a painful application, and in sensitive patients, as has been recommended, the eyes may be cocainized. In most of the instances, however, this precaution has not been deemed necessary. These observations are based upon the experience of about thirty cases.—*University Med. Mag.*, July, 1890.

The Antiseptic Treatment of Typhoid Fever.—According to Dr. Petresco, who has been employing bisulphide of carbon in the treatment of typhoid fever, the difference in the mortality of cases treated in this way from that of cases treated according to more usually recognized systems is very considerable. The mixture prescribed was of the strength of 2 per cent., the vehicle being mint water. Of this mixture from three to four ounces were ordered daily. The mortality of typhoid in Bucharest is generally from 25 to 38 per cent., but under the bisulphide of carbon treatment Dr. Petresco lost only 10 per cent. of his cases. Even more remarkable were his results with β-naphthol, of which from forty-five to sixty grains were given per diem. Under this treatment he lost only 4 per cent. of the cases. Sometimes wet sheet-packing was combined with the internal medication, sometimes not. He states that not only was the mortality diminished under bisulphide of carbon or β-naphthol, but that the whole course of the disease was rendered milder, and there was a remarkable immunity from serious complications.—*Lancet*, May 24, 1890.

Jones (E. L.) on Some Properties of Sodium Silico-Fluoride.—In some experiments to test the germicidal power of this drug sold as "salufer," the author found that when of proper strength it precipitated albumens, and in this way he thinks it exerts its antiseptic action as does alcohol, mercuric chloride, and picric acid.

With regard to its internal administration, the author can corroberate the results of those who describe it as not so innocuous as it has been represented. A single dose of two grains produced in one case discomfort and nausea. A quarter of a grain thrice daily, exhibited for some weeks, produced, however, no ill effects.

It appears not unlikely that it may be decomposed within the body in the same way that it is by sodium carbonate, glass, etc., and that after absorption it is as useless as an "internal germicide" in infective disorders as it is in certain cases in the laboratory.—*Brit. Med. Jour.*, June 21, 1890.

Parsons (I.). Further Report on a Case of Cancer of the Breast Treated by Electricity.—The growth had been arrested for a year and eight months. The patient, aged thirty-eight, was under treatment for three weeks in August and September, 1888; since then she had not required further treatment. The growth previously to the treatment had been rapid, involving three axillary glands, and causing marked retraction of the nipple. The stroma remained unabsorbed, and formed a complete skeleton of the growth.—*Lancet*, May 24, 1890.

Reid (J.) on Iodism from a Single Intra-Uterine Application.—In 1883 I swabbed the interior of the uterus of a lady who had lain for six months in a specialist's hospital, suffering from metritis, with enlarged uterus, with little or no bene-

fit. Iodism followed within twenty-four hours, and again a fortnight later, and pregnancy soon after. In 1889 I swabbed two—both, however, for diseased endometrium, connected with retained decidua of some duration, containing much granulation tissue—with iodized phenol. Iodism followed in each case. In neither would absorption be favorable.

Iodized phenol contains āā 3 j iodine, camphor, carbolic acid, and chloral. I never got all the iodine to dissolve, and never used more than 3 j iodine at a sitting. There is no pot. iodide to keep the iodine in solution after injection.

Gynæcologists' dictum, that the endometrium does not absorb, has appeared to me to be more an idea than a fact, the absorption of products following labor being in point.—*Australian Med. Jour.*, April 15, 1890.

MEDICINE AND PATHOLOGY.

Prudden (T. M.) on the Germicidal Action of the Blood-Serum and other Body Fluids.—Fresh blood-serum possesses, though in different degrees in different animals, and in varying potency with the different bacterial species, a most marked germicidal power; that a similar germicidal power resides in fresh human non-inflammatory transudations; that this power is not directly associated with the formed elements of the blood or transudates, but is in some way dependent upon their albuminoid constituents. It would furthermore appear that this singular, and apparently most significant, capacity of the body fluids is intimately associated with that complex condition which we call life.—*Med. Record*, Jan. 25, 1890.

Hæmaturia and Garden Rhubarb.—An anonymous correspondent writes to the *Lancet*, June 28, 1890: "Six years ago my son had a sudden attack of hæmaturia, but having been playing leap-frog at school it was thought probable that the kidneys had suffered some injury. This symptom quickly passed off with rest in bed, and nothing further came of it until a year later, when it recurred, and was again attributed, in the absence of any known cause, to renal injury from athletic exercises; and, there being apparently some tenderness on pressure over one kidney, calculus suggested itself. A third attack followed at an interval of another year, when microscopical examination of the urine, then made for the first time, revealed the presence of numerous octahedral crystals of oxalate of lime with blood-cells. I at once suspected garden rhubarb as the cause, each attack having come on when it was in season and had been freely partaken of. He therefore abstained from that vegetable in future, and has had no recurrence of hemorrhage. In the early spring of this year I was myself similarly attacked with hæmaturia, accompanied by frequent desire to micturate, and smarting pain in the urethra. The microscope showed abundant sharp crystals of oxalate of lime and blood-cells, and, having just previously partaken freely of stewed rhubarb, I felt convinced that to this the hemorrhage was due. It is hardly necessary to add that this vegetable ceased to appear at my table."

Another anonymous letter to the *Lancet*, July 5, 1890, contains the following:

"For years I used to suffer from painful micturition after eating rhubarb. The irritability of the bladder and dyspnœa generally came on during the night after taking it at late dinner. The symptoms, however, were not so severe as to deter me altogether from taking it in small quantities. On one occasion, five years ago, I hurriedly, and without remembering, partook freely of rhubarb dumpling at luncheon. In the afternoon intense dysuria seized me, and was accompanied by profuse hæmaturia, which lasted for four days. Since then I have abstained from it. The condition of my bladder and kidneys is, and has been, absolutely healthy. They have never given me any trouble except after the use of rhubarb. One can use it almost with impunity if he uses it very early in the season, when it is quite young. I suppose there are fewer oxalates in its early growth. I have met with two other persons similarly affected."

Dr. William O'Neil, in the same number of the *Lancet*, records a small epidemic of kidney complaints, including hæmaturia, which he traced to garden rhubarb and the free ingestion of hard water. He considers the simultaneous ingesting of lime of some form important or essential to the production of hæmaturia.

Hankin (E. H.) on Poisonous and Defensive Albumoses.—The author has found that a proteid body extracted from the spleen and lymphatic glands of

cats—a globulin—has the power of killing certain pathogenic bacteria. The globulin appears to be identical with Halliburton's cell globulin β, a substance which that author believes to be fibrin ferment. This globulin can be precipitated with alcohol, and dried without losing its germicidal characters. The method employed was the same as that used by Buchner when testing the bacteria-killing power of blood serum. Mr. Hankin's results appear to have a great theoretical interest, as shown by the conclusions which he draws from them, which are as follows: 1. That Halliburton's cell globulin β possesses a bacteria-killing power. 2. That this power appears to distinguish it from fibrin ferment. 3. That this bacteria-killing power is of the same nature as that possessed by blood serum as described by Buchner, Nissen, and Nuttall. 4. That this power of the serum is probably due to the same or some allied substance. 5. That inasmuch as it is possible to obtain from cells that are or can become phagocytes a substance having bacteria-killing powers, we may suppose that phagocytes can not only kill microbes that they have ingested, but also do this by breaking down and liberating their contents.

It is obvious that this discovery throws a new light on Metschnikoff's phagocyte theory, and points to an explanation of the *rationale* of pus formation. Apparently we are dealing with a natural antiseptic—a substance produced by the organism to protect itself against microbes, and the question arises whether its administration can have an effect in modifying the course of the disease. Mr. Hankin's results in this direction, though entirely of a preliminary nature, are not without interest. Though in some cases an injection of cell globulin after anthrax inoculation produced no noticeable effect, in other cases the life of the animal was prolonged, and on its death the bacilli showed different signs of degeneration, and many of them were included in phagocytes.

Mr. Hankin's work seems to indicate that in the conflict between the organism and the microbe both parties choose their weapons from the same armory, namely, that of poisonous proteids.—Editorial, *Brit. Med. Jour.*, May 31, 1890.

Microbes in Hailstones.—Bacteria of various kinds have been found in ice and snow, and Dr. Fontin, a Russian observer, has now proved that hailstones are not free from them. He has found that the water produced by the melting of hailstones contains on an average 729 bacteria per cubic centimetre. Neither yeast, fungus, nor mould was present, but nine different kinds of bacteria were found, five of which (B. mycoides, liquefaciens, luteus, sarcina lutea, and aurantiaca) are already known. As the ordinary dwelling-place of the bacillus mycoides is the earth, we are confronted with the fact that microbes of terrestrial origin may be carried up into the air, and thus rain, snow, and hail may be the direct means of conveying infection.—*British Medical Journal*, June 21, 1890.

Ruffer (M. A.) on the Destruction of Micro-Organisms during the Process of Inflammation.—Among the micro-organisms which, when inoculated into animals, produce well-marked naked-eye and microscopical lesions at the point of inoculation must be reckoned the characteristic bacilli met with in the disease generally called quarter-evil in this country (*charbon emphysémateux*, *Rauschbrand*). This disease, as Arloing, Cornevin, and Thomas have proved, is caused by a specific bacillus, to which these observers have given the name of *bacterium chauvoei*.[1] The bacilli are anaërobic organisms, and may be cultivated in beef-broth or gelatine, provided these media have been freed from air by a stream of some inert gas such as hydrogen or ordinary coal gas. The bacilli closely resemble in appearance those of anthrax, but differ from the latter in being very motile, somewhat shorter and thicker. Lastly, the bacilli often contain well-defined spores at each end.

From his experiments the author concludes that: 1. The inflammatory process consecutive to the introduction of the bacilli of quarter-evil under the guinea-pig's skin is a protective process, and serves a useful purpose.

2. The destruction of micro-organisms at the point of inoculation is carried out entirely by the amœboid cells present in the inflammatory exudation.—*Brit. Med. Jour.*, May 24, 1890.

Davis (N. S., Jr.) on the Physiological Action of Typhoid Fever Poison.—We may summarize our conclusions as to the physiological action of the typhoid poison as follows: 1. The cause

[1] The term bacillus chauvoei is a far better name for it, for the micro-organism presents all the characteristics of a bacillus, and I therefore adopt it.

of typhoid fever produces inflammation of the adenoid bodies in the intestines, and the accompanying catarrhal inflammation. 2. General symptoms are not the result of the typhoid ulceration of the intestines, but of something (an intoxicant) formed and usually absorbed in the course of the inflammation. 3. The lymphatics are probably the vessels by which the toxic agent is at first chiefly carried from its source. 4. The typhoid poison, presumably by acting upon the nervous system, produces pyrexia, which is the result of increased tissue-change that, probably by the direct action of the poison on the tissues, is perverted in a manner peculiar to the disease, and is characterized chiefly by imperfect oxidation. 5. The typhoid poison also inhibits tissue-repair, and therefore produces bodily waste. 6. These tissue-changes result in various anatomical changes, such as cloudy swelling of most glandular organs, waxy or fatty degeneration of many muscles, and destruction of some blood-cells. 7. They also result in various physiological changes, such as diminished secretion from glands, salivary, gastric, hepatic, renal, sudorific, and probably bronchial mucous. 8. The heated blood increases the rapidity of the respiration and of the heart's action. 9. Some of the products of the perverted tissue-changes act toxically to the nervous system, and produce the mental and nervous symptoms characteristic of the disease. 10. Bronchitis is probably the result of irritation of the dry and unprotected membranes by the inspired air. The frequent coincident attacks of catarrhal pneumonia are due to an extension of the bronchitis; croupous pneumonia to superimposed infection; hypostatic engorgement to weakened circulation, respiration, and the prolonged dorsal decubitus. 11. Peritonitis is due to the extension of the original inflammation from the intestines to the peritoneum, or more frequently to perforation of the intestine by ulceration. 12. Parotitis is due to superimposed infection, probably from the mouth, which takes place with especial ease while the gland is functionally inactive. 13. Pustular eruptions are also due to superimposed infection.—*Medical Record*, Dec. 28, 1889.

Peritonitis in Typhoid Fever.—Dr. Rennert reports three cases of typhoid fever with perforation of the bowel which recovered. In an interesting paper on the subject he states that he finds that peritonitis may occur, even when there is no actual perforation, from the passage of pathogenic organisms through the partially destroyed walls of the ileum. As a rule, the peritonitis set up in this way is of a more circumscribed character than that which is caused by perforation; but, nevertheless, in some cases it is so extensive that it is impossible to avoid mistaking it for that due to perforation. For the purpose of prognosis it is of great importance to make out whether the flatus permeates the whole abdominal cavity, or whether it is confined within a limited area by the matting together of the coils of intestine. Dr. Rennert considers that the well-known sign of disappearance of the liver dulness is a strong proof in favor of the generalized affection; but if there be no change in the hepatic area, the prognosis is far more favorable. In this latter case it is quite possible for the patient to recover, but in the former the diffuse peritonitis which results invariably leads to a fatal termination. — *Lancet*, May 31, 1890.

Orchitis in Small-Pox.—Chiari has continued researches in this subject, which he first published three years ago. He then compared the lesions in the testis, which he held to be almost constant in small-pox, to the lesions in the integument. He carefully examined the testes of 62 patients, 13 during the period of eruption, 28 during suppuration, 14 during desiccation and desquamation, and 7 during convalescence from small-pox. In 45 of these cases orchitis was present; only 10 were adults, but age does not seem to have any special influence. When the testicles could be examined microscopically three zones could be distinguished in the testis, corresponding precisely to those of a variolous pustule, a central zone where necrotic changes were complete, a middle where the cells were destroyed and the connective tissue much infiltrated, and a peripheral zone where exudation was beginning. As this form of orchitis does not appear to go so far as the suppurative stage, the destroyed elements must be absorbed. In a few cases, especially in those dying during the suppurative stage, micrococci were detected. Professor Chiari considered that, since orchitis was so common in small-pox, and since the lesions in the testis were so like those in the skin, inflammation of the testicle was a true specific symptom of small-pox.—*Brit. Med. Jour.*, May 24, 1890.

Erdmann (J. F.) on a Case of Cerebro-Spinal Meningitis, with Remarkable Diminution in the Number of Respirations.—A woman of twenty-five was seized, August 3, 1889, with an occipital headache; temperature, pulse, and respiration normal. In the following six days well-marked symptoms of cerebro-spinal meningitis developed.

On August 10th, at 1 A.M., the respirations had fallen to 7, pulse 56, temperature 98.5°. There had been but half a grain of morphine administered during the preceding eighteen hours. She complained of soreness of the throat, inability to swallow readily, and rigidity of the jaws. At 1 P.M. the clonic spasms of the lower extremities had increased, while the trismus had diminished slightly. At 11:30 P.M. the respirations had fallen to 4 in a minute; patient had had but one grain of morphine and one ninetieth of a grain of sulphate of atropine during the preceding thirty hours. A hypodermic of one fiftieth of a grain of sulphate of atropine was administered, and within three hours the respirations were 9. The pain in the back had extended to the dorso-lumbar region, and that in the head to the frontal.

On the following day the respirations had fallen to 6, when one one-hundredth of a grain of sulphate of atropine was administered by the mouth.

During the 12th of August the patient vomited several times. Temperature 98.5°, pulse 72, respirations 13. During the night and early morning of the 13th the vomiting continued half-hourly.

On the morning of the 14th her arms became rigid, and remained so throughout the day. Her mental condition was considerably more apathetic. Temperature 97°, pulse 58, respirations 15.

At 11.45 A.M. on the 15th temperature was 97.6°, pulse 80, with very deep respirations of two to three a minute. She complained of a sense of oppression in the chest and intense pain in both back and head. The remedies administered were sulphate of atropine one one-hundredth of a grain and morphine one-sixth of a grain hypodermically, with 3 jss. of aromatic spirit of ammonia. At 3 P.M. respirations were 3; it was then observed, after the administration of aromatic spirit of ammonia, that she had six or eight very shallow respiratory movements, scarcely noticeable, in conjunction with the three deep ones, during which no respiratory murmur could be detected. At 10 P.M. the respirations were 16, temperature 98.2°, pulse 70, photophobia and phonophobia somewhat diminished.

On the following day the pain in the back and head was less intense. She partook of nourishment for the first time during the attack with great relish.

From this time on her progress toward recovery was rapid, although there was remaining considerable dull pain in the head and dorsal region on September 10, 1889. During the major portion of her illness there was a happy delirium mild in character.

The treatment pursued was with morphine, cathartics, sulphate of atropine, and iodide of potassium in beginning dose of eight grains, increased one grain and a half each dose till twenty-five grains were being taken, three times daily. This dose after two days became intolerable, and was diminished to twenty grains. Locally, blisters and sinapisms were applied in conjunction with the ice cap.

It may be of interest to state that the patient had been nursing a case from the South presenting sufficient symptoms to justify the suspicions of its having been a case of cerebro-spinal meningitis; also that Leyden attributes the diminished and Cheyne-Stokes respirations observed in the late stages of this disease to pressure upon the medulla produced by œdema, basing his opinion on the observations of Schiff after the artificial induction of hemorrhage in the vicinity of the medulla in dogs.—*New York Medical Journal*, Jan. 25, 1890.

Uræmia as a Sequela of Diphtheria.—Although uræmia is not commonly recognized as a possible consequence of diphtheria, it is occasionally found occurring in this way, and Dr. J. Cassel has recently reported in a German journal devoted to the diseases of children two cases which were met with in Dr. Baginski's polyclinic.

The first was that of a little girl nearly five years of age, whose urine had contained blood and a considerable quantity of albumen from the fourth day after the commencement of the diphtheria. Death took place on the thirteenth day from uræmic convulsions and dropsy. Shortly before death the child became paralyzed on the the right side. At the

post-mortem examination, parenchymatous nephritis and œdema of the pia mater were found, but no anatomical cause for the hemiplegia could be detected. The second case was that of a little girl of three years of age. Here not only the throat, but the vulva was affected by the diphtheria. The local disease passed off, and the child was apparently recovering when on the eighteenth day the secretion of urine suddenly diminished very markedly, and albuminuria and convulsions came on. Death occurred two days afterwards. At the post-mortem examination it was found that there had been in the first place parenchymatous nephritis, and that this had been accompanied by glomerulo-nephritis. There was also fatty degeneration of the heart.—*Lancet*, Jan. 4, 1890.

Barrett (J. W.) on the Microscopical Examination of the Sputum in Cancer of the Mediastinum and Lung.—A man, of about forty years of age, had suffered for some time from an affection of the thorax, about the nature of which there had been considerable doubt. In order to obtain collateral evidence bearing on the diagnosis, which had been surrounded with difficulty, his medical attendant sent me two specimens of the sputum for detailed microscopical examination. The sputum was singularly gelatinous and viscid. When turned out of the vessel in which it was contained, it had almost the appearance of a clot; it could be drawn out into strings over twelve inches in length.

I made repeated examinations of portions of it, unstained and stained, and submitted to examination a considerable quantity of it. The result of the examination was shortly as follows: The sputum was made up of two elements—(1) the ordinary corpuscles seen in sputum, which were present in vast numbers; (2) squamous epithelial cells of varied size and shape, varying from oval and round nucleated protoplasmic cells, to flattened distorted scales. Sometimes these scaly cells were found in masses adherent to one another, and once—but once only—an imperfect epithelial nest was noticeable. The epithelial cells, like the corpuscles, were also present in great numbers. There was no appearance of lung tissue, disintegrated or otherwise.

It was evident then that (since there was no disease of the mouth) there was very active proliferation proceeding in the vicinity of the pulmonary alveoli. The squamous epithelium could not come from anywhere else; the corpuscles might. The absence of any lung tissue led me to infer the absence of primary lung disease, and the existence of something in the mediastinum causing lung irritation and epithelial proliferation.

Thus this examination showed that the disease was not phthisis. The possibility of such changes being produced by a chronic pneumonia was not lost sight of; but in such a case degenerate products would probably have been present, and such a disease was, I believe, quite excluded by the clinical characters of the case. The probabilities seemed to point to the existence of malignant disease of the mediastinum, causing pressure on the lungs, and I reported accordingly.

Not long after this examination the patient died, and when an autopsy was made a mass of new growth was found occupying the posterior mediastinum. A portion of this, together with a portion of each lung which seemed to be affected, was sent to me for examination. The tumor itself was a rather slow-growing scirrhus, and in each specimen of lung was evidence of the existence of secondary (microscopic) nodules.

Thus, whilst the conclusion arrived at from the examination of the sputum as to the nature of the primary growth was correct, the inferences whereby the conclusion was reached were only partially correct, since the proliferation of epithelium must certainly be referred, at all events in part, to the actual existence in the lungs of cancer nodules; from which is deducible the important conclusion "that cancer of the lung may cause the proliferation of sputum corpuscles, and of epithelium in vast quantities, without any signs whatever of lung disintegration."—*Australian Med. Jour.*, Nov. 15. 1889.

Acute Leucocythemia in Diphtheria.—M. Bouchut, in 1868, demonstrated that in diphtheria there is acute leucocythemia. This theory was attacked by MM. Cuffer and Sanné, but confirmed by Binault in his thesis on "Les Altérations du Sang dans la Diphtérie." In a recent thesis M. Gonthier has again treated this question, taking as a basis the researches of Brown-Séquard and d'Arsonval, who have shown that from the watery vapor that issues

from the lungs of healthy human beings and all mammals a poisonous fluid is obtained. In diphtheria the breathing passages are obstructed, and this pulmonary excretion possibly condensed and elimination prevented, and in consequence of this there is insufficient ventilation of the lungs. M. Gonthier cites several cases of diphtheria which were successfully treated with oxygen inhalations.—*Brit. Med. Jour.*, June 28, 1890.

Porcher (W. P.) on the Origin of Sputa in Subacute Cough.—The well-known fact that almost all sensations in the throat are referred to the anterior part of the regio laryngo-trachealis will account for the profound impression of patients that the secretion of sputum is entirely produced by the mucous membrane of the lungs and bronchi, whereas experience has taught us that most generally the pathological disturbances are situated in the choana or naso-pharynx, and the proofs of this are:

1st. Physiological: By irritating the parts, as in a case where an application of the galvano-cautery was made to the pharyngeal tonsil the patient asserted that, for the first time, the seat of the pain had been reached—which she had previously located behind the clavicle.

2d. Pathological: By the different causes which give rise to the cough, viz., colds and inflammations of the naso-pharynx, which, in my opinion, rarely, if ever, originate in the larynx.

3d. By the results of local treatment to parts.

Hence we may conclude from this (and opinion generally supports us in the conclusion) that, when a patient applies to us suffering from a cough, we need not administer the invariable cough mixtures containing nauseating doses of antimony, squills, ipecac, etc., but simply confine our treatment to the nose and naso-pharynx.—*Med Record*, June 14, 1890.

Convulsions and Syncope from Depressing the Tongue.—M. Vergel has recently reported a case in which syncope and convulsions were caused by depressing the tongue. The child, eighteen months old, was suffering from croup. In order to examine the throat the tongue was pressed down with a spoon, when syncope ensued. This was followed by a convulsion, and the child remained during ten hours in a torpid state, from which it slowly recovered. Bouchut has reported two cases of death from pressing down the tongue; thus to avoid such accidents this should be done during expiration, otherwise even in adults spasm of the glottis may occur.—*Brit. Med. Jour.*, June 28, 1890.

Biggs (H. M.) and Jenkins (W. T.) on Accidental Suffocation as a Cause of Sudden Death.—The authors conclude that:

1. Accidental suffocation is a common cause of sudden death, especially in children, and the cause of death usually escapes recognition.

2. Death produced by the lodgment of foreign bodies in the larynx or trachea occurs rapidly, and is sometimes almost instantaneous. The foreign body may be liquid as well as solid.

3. When death is instantaneous, it is probably the result of reflex inhibition of the heart's action.

4. In children the foreign body is usually some plaything that has been placed in the mouth, while in adults it is almost invariably an alimentary bolus, frequently meat.

5. The accidental suffocation of infants in bed by the bed-clothing and by "overlying" is a very common occurrence among the lower classes.

6. Death often results from suffocation during epileptic convulsions and during profound alcoholic intoxication.—*N. Y. Med. Jour.*, July 12, 1890.

Haupt (A.) on the Importance of the Heredity of Tuberculosis in Comparison with its Propagation by Sputum.—Among the 1500 inhabitants of Soden there are 101 who let lodgings. In most of the houses the wives, with sisters or daughters, serve and tend the tuberculous patients who come for treatment. In many houses servant girls from the neighboring villages, hired for the summer, help, making the patients' beds, cleaning their rooms, beating the carpets, removing the sputum—these occupations, so closely connected with the danger of infection, are, among others, the tasks of these persons; and it must be added that they prefer the severest cases, because, as more help is required, the remuneration is higher. In winter the members of the landlords' families occupy the rooms in which generally the most severely affected patients have lain—the rooms on the ground floor. Between 1855 and 1888,

48 of the 238 members of such families died, ten of them of tuberculosis. In six of these ten cases heredity was demonstrable, and the remaining four were due to colds and external causes. Of the 415 servant girls seventeen died, five of them of tuberculosis, also demonstrably due to other causes than infection. Within thirty years, then, among 653 persons, most of whom were for several summers with and in attendance on the patients, there were fifteen deaths from tuberculosis, none caused by infection. The same proportion prevails among other persons in close contact with consumptive patients, attendants, washerwomen, etc. As to the general mortality of Soden, the pamphlet contains the following data :—Seventy-six persons died during the last three years, ten aged from eighty to eighty-five, eleven from seventy to eighty, nine from sixty to seventy. Of these seventy-six deaths, seven were due to tuberculosis, including two cases of tuberculosis meningitis in children, and one of tuberculosis of the bones, also in a child. Of the four other cases, only one was that of a person who came in contact with patients, and this was a case of alcoholism, ending in phthisis. —*Lancet*, June 14, 1890.

Microbes of Pleurisy.—M. Netter maintains that all forms of purulent pleurisy are of microbic origin, but that the microbes producing them are of many different kinds. He has made a bacteriological examination of 109 cases of different kinds of purulent pleurisy, and found in them pneumococci, pyogenic streptococci, pyogenic staphylococci, bacillus tuberculosis, Friedländer's encapsuled bacillus, pseudo-typhoid bacillus, micrococcus tetragenes, spirilla, filaments of leptothrix, and saprogenic bacteria. [We now understand why pleurisy gives us a pain.—Ed.]—*Brit. Med. Jour.*, June 7, 1890.

Nevitt on Gangrene of the Hand Induced by a Tight Sleeve—Recovery.—A boy aged three and one-half years was restless and cross for several days, and complained of his hand, which had become much swollen and painful. The swelling and pain increased, and on Jan. 27th, his mother, on examining the hand, thought that, at a point in the palmar surface, it was "going to break." She punctured it with a needle, but nothing came away, except a drop of clear fluid ; at night she applied a bread and water poultice. Dr. Nevitt saw the case on the following day, when he found the hand and forearm greatly swollen, and of a mottled purplish color; the swollen parts felt quite cold ; there was a spot, about the size of a twenty-five cent piece on the palm, opposite the roots of the middle and ring fingers, which had become quite gangrenous. On examination it was found that constriction was caused above the elbow, by a rather tight sleeve, which, there is every reason to believe, had not been removed since the child had first complained of pain. Dr. Nevitt made a free incision in the palm, carrying the knife through the gangrenous area ; this was done with the object of relieving the great tension. There was scarcely any bleeding ; a considerable quantity of blood-stained serum however escaped ; the operation caused little or no pain. Hot linseed-meal poultices were then applied to the entire hand and wrist. The arm was relieved from the constricting influence of the sleeve. Jan. 29th, the swelling was still very great, but the circulation in the hand was much improved. During the next two days the hot poultices were continued, the swelling rapidly diminished, and the part assumed a more natural appearance ; sensation was completely restored, and free movement of the fingers became possible as the swelling disappeared. On Feb. 5th, the wound had almost healed, and the parts were in a natural condition.—*Canadian Practitioner*, Feb. 17, 1890.

Kelly (C. M.) on a Case of Dry-Gangrene, in a Boy Two and a Half Years of Age.—The patient, a boy two years and eight months of age, was of robust and healthy constitution, having no dyscrasia nor unhealthy diathesis, and there being no hereditary disease in the family. He was never sick up to this time, active and vigorous.

On about June 10, 1889, my attention was called to a dark spot on the right foot, a simple discoloration of the skin on the dorsum of the foot, over the metatarsal joint of the little toe, about the size of a quarter of a dollar, or less. The skin was not broken, nor was there any sign of injury. It was just turned dark, showing death of the tissue to that extent without any external cause. There was no fever, and the boy made little complaint. I immediately recognized the seriousness of the condition, and began poulticing with the purpose of separating the dead from the healthy tissues. In the course of a few

days it began to loosen, leaving a square, punched appearance of the edges, the black, dry centre still remaining attached at the bottom. About this time, June 15th or 16th, a line of red spots appeared along the inner side of the right leg, (showing the course of poison), accompanied with fever, which in the course of a week reached 105° F., pulse, 160, and urine normal. The dark, dry centre still remaining, I poulticed two or three days longer with yeast and charcoal poultice, and washed the gangrenous sore with bichloride solution. It still remaining firmly attached but not spreading, I had finally to dissect it away with a scalpel, and in a few days more all shreds of dead tissue had disappeared. Of all the physicians who saw him at this time almost all gave an unfavorable prognosis. After about one week the fever subsided, only to return again and again, as high as at first, for ten weeks. One peculiarity of the disease was an eruption. This eruption came in uniform shapes, in concentric rings, a red centre surrounded by a white ring, then a red ring, and so on. These were over the whole body, the legs, the trunk, the arms, and the face. Besides these regular shapes, there was a mottled, pied appearance of the skin; this was particularly marked about the face. This eruption came out with the fever, disappeared and reappeared with the fever each time, until the last few times, when the regular forms were absent, and only the mottled eruption appeared. The eruption always came when there was fever, and at no other time.

Another peculiar feature was the periods in which the fever recurred. On observation I found the fever recurred in exact periods of six days from the highest point of exacerbation one time to that of another, and lasted about two days.

Another peculiarity of the disease was the whitish, putty appearance of the stools. This I noticed after the first week, and it continued until convalescence was established, with tympanites of the bowels, which was extreme when the fever was high. The liver was slightly tender, and the cervical and inguinal glands were slightly enlarged. The flesh was always sore at the recurrence of fever. He ate heartily at all times, except during the highest fever, especially of meats.

The patient missed the paroxysms of fever after about ten weeks; he was somewhat pale and weak for a while, a flushed, mottled appearance now and then showing itself on the face, but now he is running about and seems to have made a good recovery. Quinine was used in large doses until it was found to have no effect on the return of the fever, and Fowler's solution, calomel and syrup. iod. of iron, elix. iod. bromid., calcium comp., were also used, and a free purgation at the time of high fever and tympanites.

To recapitulate, this was a case of dry (senile) gangrene in a child two and a half years of age, followed by fever, which recurred in regular periods of six days, with a peculiar characteristic eruption. (That this form of gangrene should appear in a child is very strange, and so is the subsequent history.)—*Med. Record*, July 5, 1890.

De Saussure (P. G.) on a Clinical History of Twenty-two Cases of Filaria Sanguinis Hominis.—The author tabulates and analyzes these cases as follows: The disease was distributed a s follows: 9 colored males, 6 colored females; 5 white males, and 2 white females. Of the 22 cases 16 were in married people, all of whom had children. In over one half of the cases filaria were searched for in children of the married, in husbands or wives, or in friends and bed-fellows of the single ones; and yet but in a single instance did I find two cases in the same house. In the child of one case I think, if the search could have been carried on, filaria would have been found.

As to the social conditions of the patients, 15 were colored, 7 white; of the latter only 3 can be said to be in high life. All of the others, black and white, belong to the lower and middle classes. Why this difference? Is it from abode or diet? The houses of our domestics and laborers are very similar to those of the same classes elsewhere.

In reference to the diet and water, the former is that of the working-class in other cities, only that here they eat a great deal of fresh fish—in fact, during the summer months fish of some sort takes the place of meat. As to the drinking-water, I know from a ten-years' practice amongst the lower classes that it is mainly pump or artesian, and exceptionally cistern water. Sometimes, for a short period just after rain-storms, the poor have barrel water, but the supply soon runs out, and they go back to the pumps and artesian wells. A word about the barrel water, which

is rain-water caught in barrels and casks open to dust and dirt, and one can always find with the microscope many living things in the water. The same is true of the artesian water, which, though it comes from wells 1,800 to 1,900 feet deep, is, before being served, stored in an open reservoir, which, to the best of my knowledge and belief, is bricked halfway down the sides, but only puddled at the bottom. I am not enough of a microscopist to say to what class the animals found belong, but know this, that with the microscope I have spent hours seeing them fight and destroy each other. The better class of Charlestonians drink cistern water. As to mosquitoes, I think they are as common in the homes of the rich as in those of the poor.

Diagnosis of the disease can alone be made with the microscope, for by reference to the table attached to this paper we find that chylocele, chyluria, lymph-legs, and glandular enlargements are frequently found, yet examinations of the blood may fail to show filaria. Again, we find filaria without any of these disturbances.

There is no pathognomonic symptom. Sometimes we have fever and chills, at other times neither. The disease, as a rule, does not appear to prevent the patients from working. Two of my cases are exceptions, and some of the other patients were for a time disabled, but returned to their duties, and the filaria were still found when looked for. The chyluria is intermittent, and in no case that I have seen was it always present; and I would state further, that during its presence a given specimen of blood would not show more filaria than another specimen examined when chyluria was absent. In but two cases have I ever failed to find filaria after having once seen them. In one case, his residence for three months at Flat Rock, N. C. (at an elevation of 2,000 feet above the sea-level), always reduced the number of filaria, but after being in Charleston for eight months they became numerous again. Would they entirely disappear if he remained in the mountains?

To show the impossibility of making a diagnosis without the microscope, I would state that during the last three years I have examined three cases of chylocele with negative results (blood of two, fluid of one).

Six cases of chyluria and one of hæmatochyluria have also given negative results, though one of these may yet prove to be a case of filaria, for it occurs in a patient who is a printer, and as yet I have not been able to examine him at the end of his work, which is about 5 A.M. Five cases of elephantiasis of the leg have been under observation, but no filaria were found.

Learning from our veterinary surgeon, Dr. Benjamin McGinnis, Jr., that filaria were very common in the dogs of Charleston, with his and Mr. L. W. Bacaise's assistance I made some observations on the disease in the dog, I found that the embryo filaria in man and dog are identical—those of the man being possibly a little larger and their movement more active and strong. Very early in the investigation I was surprised to find that in the dog the embryo filaria could be found at any time of the day or night. In man it is different, for I have been able to find them in the day but twice, once at 10 A.M. in the negress from Africa, and once at 5 P.M. (summer) in another case.

Carrying the investigation still further, I examined fleas from filarial dogs, but got negative results until the morning of May 14th, when I found two filaria in the body of a flea which was taken from a diseased dog. This observation will, I hope, be confirmed, for it may throw considerable light on the mode of infection. I had purposed to make some examinations on the puppies of an infected bitch, but time has been wanting. I therefore would suggest that any one interested in the subject may, by such examinations, clear up the question of heredity.

In the dog the disease causes death from ascites, which seems to be in consequence of the adult filaria collecting in the heart, a condition that we found in five post-mortems.

It is worthy of remark that in the one case of death occurring in a patient known to be afflicted with filaria—the cause of death was "dropsy with heart failure"—no post-mortem was allowed, so the presence of the adult filaria in the heart was not proven. It is suspicious that four cases should have heart murmur and dropsy.—*Med. News*, June 28, 1890.

Romberg and His on the Innervation of the Heart.—From their experiments the authors are convinced that the cardiac ganglia are sensory in their function. The cardiac muscle thus appears to be of a greater importance pathologically than heretofore. Whereas the changes of

the cardiac ganglia, owing to their complicated action, did not permit of a clear explanation of the pathological irregularities of the cardiac function, whereas the effect of cardiac poisons could not easily be referred to an influence on the cardiac ganglia, the examination of the cardiac muscle will in future more frequently reveal the cause of the morbid action of the heart.—*Brit. Med. Jour.*, May 24, 1890.

Lee (R.) on Disease of the Heart Resulting from Emotional Causes.—The patient was a nurse, twenty years of age, a well-grown girl, with good family antecedents, and without history of any disease possibly affecting the heart. For eighteen months she had been gradually losing health and strength, and developing the symptoms from which she was suffering when I saw her. These were marked debility, slight anæmia, and troublesome palpitation of the heart. She could not walk without distress from breath-shortness; she had pains in the thighs and some swelling and induration of the tissues, such as to suggest phlebitis of the saphena or deep femoral veins. The cardiac pulsations were generally 140 per minute; they would rise to 150 if she got up or if she were the least excited. After rest in bed and treatment the pulsations diminished to 120 for a few days, but returned to the higher number. Thus she continued for two months, with little if any improvement in respect of the condition of the heart, though relieved of local pains and feeling generally somewhat stronger. Digitalis did not have any effect in this case, but small doses of opium at first quieted the heart. The cause which was assigned by the patient for this condition of ill-health was the following; and by evidence from other sources the absolute truth of her statement was confirmed. One day, when sitting in the nursery with the children, their father came into the room in a state of mental derangement, and seizing hold of the youngest, an infant, acted with the apparent intention of throwing it out of the window. The girl was so overcome by terror that, as she told me, she was unable to move or speak. From this occurrence she dated her illness. The case resembled in many respects one of Graves' disease, with the exception that there was no protuberance of the eyeballs or enlargement of the thyroid. The heart's action was regular, though rapid, the pulsations strong and evident to the eye. There was also increased pulsation in the large arteries in the neck. There was a faint systolic bruit heard over the apex area. At the end of two months the patient returned home, and I have not heard what course the malady took since that time. It must have been observed that irregularity and increased pulsation of the heart frequently occur in children suffering from chorea, when there is no association of chorea with rheumatism, and no evidence of valvular affection. It seems probable that this peculiar symptom of increased cardiac pulsation is due rather to derangement of the nervous system of the heart than to a distinct organic lesion of the valvular, muscular, or other tissues. Although it may be impossible in our present state of pathological knowledge to give any explanation of the nature of the morbid condition of the nervous system of the heart which is indicated by increased pulsation or irregularity of action, and which is attributed to emotional disturbance, it is well to admit the clinical evidence of its possibility; and generally, though such derangement of the heart's action may be of temporary duration, occasionally, though rarely, it may be of more serious and permanent character, as in the case briefly related above.—*Lancet*, Feb. 22, 1890.

Hare (H. A.) and Martin (E.) on the Effect of Section of the Phrenic Nerves.—The authors conclude that: 1. Injury or destruction of the phrenic nerves is not followed by death, as has heretofore been taught. 2. In injuries involving the diaphragmatic movements it is important that the patient shall not be anæsthetized, as under those circumstances the absence of voluntary aid in respiration may be attended by fatal results. 3. The seriousness of phrenic injury is in direct ratio to the independence of the respiration of the normal animal on the diaphragm and to the ability of the chest-walls to make compensatory movement. 4. The symptoms resulting from interference with the function of the phrenic nerves are as definite and characteristic as those following interference with any other motor-nerve. There will always be well-marked increase in the scope of the thoracic excursions and distinct reversal of the movements of the abdomen, *i.e.*, the abdomen will retract on inspiration. 5. Fear of injury to one or both phrenic nerves need not prevent

operations about the neck and upper portion of the chest, provided that due caution be exercised that the patient is but slightly under the influence of the anæsthetic at the time that danger of injury to these nerves is most imminent. Infancy, however, constitutes an exception to this rule; only absolute and pressing necessity for operation would afford justification for such a procedure in early life. 6. The real effects of section of the phrenic nerves being known, it follows that the nerve is subject to the same operation in case of injury as are other nerves of the body, such as suture. 7. In cases of injury to the phrenic nerves support should be given to the abdominal walls, to prevent movement of the same and to brace and steady the paralyzed diaphragm, care being taken that the floating ribs are free.—*Lancet*, Jan. 25, 1890.

Hochwart on Psychical Disorders Occurring after Operations on the Eye.—It has been known since the time of Dupuytren and Esquirol that psychical disturbance may follow operations on the eye; the fact has also been noticed by Sichel, Schnabel, Schmid-Rimpler, and others. Dr. Frankl has dealt with thirty-two cases, which he divides into four classes. The first comprised fifteen patients between the thirtieth and ninetieth year of age. The psychical disorder had the character of "hallucinatory confusion" in the sense of Meynert; aural and visual hallucinations of a terrifying nature formed the chief features of the delirium. The second class comprised seven patients of alcoholic antecedents. The third class comprised seven aged individuals in whom simple confusion and dementia without hallucinations, followed operations on the eye. Finally, there were three patients in whom operation was followed by other somatic conditions, which led to a fatal issue. During these affections inanition delirium was observed. The operations were chiefly for cataract. Mental disturbance was, however, also noted after iridectomy, operations for squint, and enucleation of the eyeball. The prognosis of the psychosis was not always favorable; it might last for months and years, and frequently ended in dementia. These cases might, perhaps, be reckoned among those in which the mental derangements followed surgical operations in general. They were, however, proportionately so frequent after operations on the eye that other causes had to be sought for. The following points had to be taken into account:—1. The numerous nerve tracts connecting the eye with the brain; lesions of the eye also occasionally produced psychical affections. 2. The irritation of sensory organs might also be reckoned among the causes of madness. 3. The predisposition created by the depression caused by blindness. Dr. von Frankl cited cases in which mental disturbances occurred during the time blindness was coming on and recovery following operation. 4. The advanced age at which operations for cataract were frequently performed. This was, however, only true of a certain number of cases, as psychical diseases after eye operations were also noted in young persons. 5. The influence of the darkness cure was also very important, as darkness had a depressing influence, and there were individuals who became affected with hallucinations on mere closure of the eyes. Dr. Schmid-Rimpler had seen two cases of mental disturbance from shutting out the light without any operation. Psychical affections followed operations which did not require the darkness cure, but it was certain that the longer the darkness cure lasted the greater was the disposition towards mental disturbances.—From the *Jahr Bücher für Psychiatrie* in *Brit. Med. Jour.*, June 28, 1890.

The Hypnotic Epidemic.—We are passing at this present moment through a mental epidemic which may be called the hypnotic, or the epidemic of hypnotism. These mental epidemics are very similar to those that are purely physical. They often take the spreading form which constitutes them epidemical. They start from one particular centre, and follow special lines of human intercourse. They recur in regular series, appear, disappear, or nearly disappear, then reappear in full force, arrest the attention of the world, and once more subside. They seem to be modified by external conditions, and it might almost be said by seasons, or at all events by cycles or courses of years. In the phenomena by which they are manifested the bodily or physical phenomena combine with the spiritual or mental, both leading to certain aberrations which may most correctly be designated disease, or diseased condition, of body and of mind.

What will be the effect of the hypnotical

and suggestive methods on the practical life of the world?

The answer to this question is clear, if the present experience may be tested by that of the past. By such test it may be assumed that for the temporary annihilation of pain the hypnotic method will never become a serious rival of the physical anæsthesia, local and general, produced by ether and the other volatile substances. To make the hypnotic anæsthesia universally applicable we should require to have universal change in the nervous organization, under which the brain would be rendered susceptible beyond the common susceptibility to external impressions. This would mean a transformation of mankind into a new and truly miserable mental condition, an event not likely to be developed in an age when strength of intellectual growth is the grand necessity of the day. Limited at this moment to the few who are susceptible to it, hypnotism must become still more limited as enlightenment goes on. As a method for producing oblivion from pain it will be further limited, in application, to short seasons of special social or meteorological cast; and if it fail, the influence of suggestion will fail with it.

Bringing the mind to adjudicate on the whole matter, is it not truly a happy circumstance that the forecast relating to both the hypnotism and the suggestion is towards their extinction rather than their advancement? Their advancement could mean nothing but weakness, the strong leading the weaker, the weaker the weakest. In this way it never can have been ordained that the human mind should travel through the ages. With such a prospect in view, an enthusiast like Dr. Tuckey himself would hardly be satisfied, nay, it is obvious that he sees for the phenomena he relates a necessity for two natures—one the susceptible or enfeebled, the other the commanding or the strong; a terrible division unless we wish all our health and strength to die.

But if the hypnotic phenomena are passing vanities, from them a lesson may grow, touching the education of the young, of inestimable value. Before the adult man and woman, but chiefly the mother-woman, the young child is always under the dominion of hypnotism and suggestion, and suggestion made on the young mind often goes forth as an order for life, for good or for evil. What number of uncontrollable acts, follies, passions, are due to such hypnotism and suggestion on the susceptible child, few have conceived; albeit they are the foundations of the good and of the evil of our common humanity.—*The Asclepiad*, No. 26, vol. vii.

Hypnotism in Belgium made a Misdemeanor.—The Academy of Medicine of Brussels, having memoralized the Belgian Government in condemnation of all public hypnotic exhibitions, a regulation has been adopted forbidding them. The only uses of hypnotism hereafter legally to be practised will be medical and therapeutical. The practise of hypnosis on girls under the age of 18 years is made punishable by fine and imprisonment.—*Jour. Am. Med. Asso.*, June 14, 1890.

Menstruation in the Male.—A correspondent who desired that his name be not mentioned, writes as follows to the *Weekly Med. Review*, July 7, 1890:—The patient was a man well developed, with slender waist and feminine disposition, and a respectable growth of beard. Married, with one child. The peculiarity was that he menstruated regularly (every month) with all the phenomena of ordinary female menstruation. The backache was so severe that he asked my advice about the use of opiates. The discharge from the penis was smartly tinged with blood and lasted for three or four days, after which he felt cheerful and well. He always wears a "Mother Hubbard" when about the house and has many other feminine peculiarities. The penis is well developed. There is no hypospadias. He seems to enjoy the sexual act as much as other men.

A New Urethral Coccus.—M. Ebaud has found in the normal male urethra a staphylococcus presenting the same characteristics as the gonococcus, and cultivated in the same way. M. Ebaud thinks that this staphylococcus which develops under the same conditions as a saprophyte in the normal urethra, is capable, under the influence of certain, yet undefined conditions, of setting up blenorrhagia.—*Brit. Med. Jour.*, May 31, 1890.

Sutton (E. M.), on an Interesting Case of Self-Mutilation.—May 30th, 1890, a young married man, 29 years of age and the father of two children, secured a razor at midnight and deliberately ablated testes and penis. The only surgical aid given was to arrest hemorrhage, and an iodoform dressing. The wound has

been dressed daily, and although in healthy condition, seems to have made but little progress. The stump of penis is about an inch long, the skin retracted from it; the cut surface represents a typical cross-section, and exhibits but slow intent to heal, probably on account of the peculiar blood-supply of the corpora cavernosa and corpus spongiosum.

It has been suggested to shave the pubes, freshen and unite the edges of the skin over the stump, and to leave a catheter in the urethra until healing takes place. As the patient is to be removed to an asylum, I cannot at present report the ultimate result.

The history of the patient is interesting, as it bears on the subject of sexual excesses.

He is of nervous temperament, and the unfortunate husband of a woman endowed with a gluttonish venereal appetite. He finally broke down completely. His wife twitted him as to his inability to satisfy her, and left him, emaciated and haggard, for stronger bucks. This preyed upon his mind till he obeyed the insane impulse to rid himself of the original cause of his condition.

It remains to be seen whether or not he will be be helped by this most radical treatment.—*Med. Age*, June 25, 1890.

Watson (W. S.) on Addison's Disease, with a Report of an Autopsy.—A man, aged 40 years, presented a pronounced bronzed appearance for about four years previous to his death. He was of a dark, bilious complexion naturally, possessing a delicate constitution, and a hatter by trade. During the last two years of his life he complained of what he thought were bilious attacks, which caused pain in his kidneys. His family history gave no evidence of phthisis; it is believed that one sister died of cancer of the womb. We were called to see him on November 22, 1888. We found him suffering from the effects of a decided chill, which was due to exposure in a rainstorm while attending the funeral of his wife. The surface of his entire person was cold, his pulse slow and weak, constant nausea and vomiting, complete loss of appetite, skin much bronzed—in fact he presented a decided mulatto appearance. He was very much emaciated, nervous and restless. His nervous system had just received a severe shock by the loss of his wife, who died two days previously. He complained of some pain in the stomach and in the region of the kidneys. He was inclined to lie in a semi-comatose condition a part of the time; at times his mind was clear, and he could converse intelligently.

Nearly all the medicine given to him was rejected, though some stimulants were retained, and external warmth was applied, which had the effect of restoring the circulation sufficiently to get him warm. We visited him daily until December 1st, when he died. On December 2d we made an autopsy. The heart was first examined and presented nothing abnormal. The stomach was almost normal in appearance, showing possibly a slight evidence of recent congestion; the liver and kidneys were normal in appearance, the supra-renal capsules on the exterior were normal, with the exception that both were considerably enlarged, the left one being about one-fourth the larger. On examination of their interiors there were found evidences of chronic inflammation which had passed successively through the stages of fatty and cheesy degeneration. Some portions of each pelvis were mere fibre sacs containing a puriform liquid and some gritty particles, the calcareous results of cheesy degeneration. The internal cell masses of a large portion were almost obliterated and the medullary substance considerably broken down, apparently from the results of inflammation.—*Jour. Am. Med. Asso.*, April 19, 1890.

Vanzant (C. B.), on the Relation of Rheumatism to Hemorrhage.—The author narrates two cases. In the first case there was a typical attack of acute rheumatism, attended with marked petechiæ of the entire body, and later with enterorrhagia, in a patient who had always previously been well. The failure of all treatment directed to the purpura exclusively, but the rapid success of anti-rheumatic treatment, not only in causing the disappearance of the rheumatism, but of the purpura as well, merits attention.

In the second case there was the occurrence of rheumatism, preceded by unaccountable attacks of epistaxis, and attended with hæmaturia (probably of nephritic origin), which latter gradually disappeared without any special treatment, as the rheumatism subsided under appropriate medication.

The treatment consisted of the salicylates, iodide of potassium, and the alkaline salts.—*Cincin. Lancet-Clinic*, June 21, 1890.

OCCASIONAL REPORT ON INSANITY AND NERVOUS DISEASES.

Thompson (W. G.) on Successful Brain Grafting.—The author's experiments consisted in transplanting a piece of brain tissue from one side of an animal's brain to the other, or from one animal's brain to another. The results of these experiments are embodied in the author's conclusions that—

1. There is complete union, through organized connective tissue, of the contiguous portions of the two brains.

2. After seven weeks the cat's brain still maintained enough vitality to be distinctly recognized as brain tissue.

3. Brains of animals of two very different species were thus made to unite.

4. The cat and dog pias present perfect union as well.

5. There is a sympathetic degeneration of the corresponding convolutions upon the opposite side of the dog's brain. For this curious fact I cannot account. I have never noticed it before, in as many as fifty operations upon this region of the brain of cats and dogs, although I have sometimes seen removal of a part of the occipital region result in extensive softening of the entire hemisphere of the same side. The opposite degeneration in this case may possibly be a mere coincidence; if so, it is a very unusual and remarkable one. There was no meningitis to favor it.

6. There was descending secondary degeneration of the dog's brain on the side of the graft, as is usual in cases of simple excision of brain cortex; hence the cat's cortex had not succeeded in acting as a nutrient centre for the dog's brain. (The microscopic specimens showing the line of union of the two brains were shown to several competent microscopists, who indorsed their appearance as herein described, so that there can be no question of the accuracy of the observation.)

I think the main fact of this experiment —namely, that brain tissue has sufficient vitality to survive for seven weeks the operation of transplantation without wholly losing its identity as brain substance— suggests an interesting field for further research, and I have no doubt that other experimenters will be rewarded by investigating it.—*N. Y. Med. Jour.*, June 28, 1890.

Hammond (G. M.) on the Pathological Findings in a Case of Athetosis. — The portion of the brain involved in the lesion was a lengthy one in the antero-posterior direction, parallel in its short axis with the internal capsule. Its posterior end had invaded the stratum zonale of the thalamus in its posterior half of the internal capsule. In its anterior extension it had crossed the capsule invading the posterior third of the outer articulus. The author called attention to the fact that the motor tract was not implicated in the lesion, and argued that this case was further evidence of his theory that athetosis was caused by irritation of the thalamus, the striatum, or the cortex, and not by a lesion of the motor tract.

Spitzka reports a case in which the lesion was found to be in the same situation as in Hammond's case.

Seguin reports a case of atheto-choreic spasm of the right side of the body. The post-mortem showed a glioma of the left thalamus opticus and adjacent internal capsule. His views were that all cases of athetoid and choreiform movements following hemiplegia were due to lesions involving the thalamus and adjacent capsule.—*Med. Record*, July 12, 1890.

Dwight (T.) on the Closure of the Cranial Sutures as a Sign of Age.—After a few preliminary general remarks, the author appends a table of one hundred observations upon people of both sexes and all ages, showing the condition of their cranial sutures.

The most evident conclusions from this table seem to be:

(1) That the sutures begin to close much earlier than has ever been stated. The process is apparent in several cases of persons under thirty. Of those from thirty to forty there is but a single case in which closure has not made progress, and in this one it is beginning. In another there is but little union to be seen on the outside.

(2) That the closing almost invariably begins on the inside, which was well known before. It seems, however, that the process does not at all necessarily appear first on the outside opposite the points previously attacked on the inside. On the contrary, in several cases one part of a suture is obliterated on the outside, and the other on the inside. The inside of the skull of a woman, of sixty-five, shows almost precisely the converse of the ossifi-

cation of the outside. What is open on one surface is closed on the other except for the lambdoidal.

(3) That the time of closure of any particular part of a suture, and the order in which the process advances, are very uncertain. In proof of this we need only compare the appearances of the individual cases of any group of five or six skulls of the same or nearly the same age in the first half of the table. As to the usual order, I shall venture only to say what I *think* about some points.

I think that closure generally begins in the back part of the sagittal, and often as soon or nearly as soon in the lower ends of the coronal. I think that when the sutures close early the coronal usually closes before the lambdoidal; but that in old skulls, on the outside, at least, the lambdoidal is more frequently obliterated than the coronal. On the inside of old skulls there is very often a minute line showing the position of the apex of the lambdoidal suture when all the others are quite gone. A persistent frontal suture is one of the last to disappear, as has been previously taught.

As to the rules for determining the age of the skull from the condition of the sutures, it is necessary only to compare them with the observations recorded in this table to see what they are worth. It must not be forgotten that there are other guides to the age of the skull; and I am not prepared to assert that, taken together with them, the sutures are absolutely worthless in the hands of an experienced anatomist. I am sure that to any one else the rules in question are misleading and dangerous.—*Boston Med. and Surg. Jour.*, April 24, 1890.

Lombroso on Criminal Anthropology.—Lombroso argues that an attentive study of the physical organization of the habitual criminal shows him to belong to a degraded type of humanity, the product of hereditary degeneration. The peculiarities observed are not constant, but certain traits are repeated more often than with normal beings. By arranging these traits in the mind the type is conceived. Lombroso acknowledges that his type fails completely in 60 per cent. of his criminals; in a few cases, too, individuals have most of the marks without being criminals; and one case has even been mentioned of an unfortunate man who bore all the stigmata of criminality without being a malefactor. Nevertheless, certain bodily peculiarities are found to be commoner with criminals than with normal individuals, and the occurrence of a greater number of these peculiarities makes him approach nearer the type. The principal of these stigmata are smallness of the head, asymmetry or abnormal forms of the skull, unequal size of the orbits, teeth irregularly placed, abnormal forms of the palate, and increased size of the lower jaw. There is also a great variety of irregularities in the shape and position of the external ears. The stature is generally low; left-handedness is commoner than in honest men, and in some cases the left hand is longer than the right, and the stride of the left leg is greater. The sensibility to pain is deficient, and the perceptions of taste and smell have been proved to be less accurate than with ordinary beings. The brain of the criminal presents miscellaneous irregularities; various anomalies of the gyri have been pointed out by Professor Benedikt and others, and the relative size of the cerebellum to the cerebrum is increased. Peculiarities in the skeleton, such as asymmetry of the throax and deficiency in the number of vertebræ, have also been noticed. The type is much more decided with the males than with the females of the criminal classes.—*Brit. Med. Jour.*, May 24, 1890.

Ellis (H. H.) on the Ear in Criminals.—Even non-scientific observers have noted the frequency among criminals of projecting or of long and voluminous ears. In the answers to my questions issued to medical officers of prisons I found that the prominent ears of criminals were more generally recognized than any other abnormality. Thus, Dr. V. Clarke says: "The largely developed external ear is a common feature"; others speak of "ears often large and outstanding," etc. Lombroso finds the ear "ad ansa," as he calls it,—the handle-shaped ear,—in 28 per cent. of his criminals; Knecht in 22 per cent., Marro not more frequently than among ordinary people. Ottolenghi, who has recently examined the ears of nearly 600 criminals and of 200 normal persons, finds that while among the latter it is found in 20 per cent., among the former it is found in 39 per cent., the percentage varying from 35 among thieves to 42 among those convicted of assault and wounding. This observation is, indeed, by no means of recent date.

In reading lately that curious treatise of mediæval physiology, Michael Scott's "De Secretis Naturæ," I found that a very bad character is given to those persons whose ears are uncommonly long, or ample transversely; they are bold, vain, foolish, incapable of work. To come down to comparatively recent times, Grohmann in 1820 noted the prominent ear as a marked characteristic of the criminal. Morel studied the abnormalities of the ear, especially in relation to heredity; and in England, Laycock fully appreciated their value as indications of degeneration.[1] Dr. Langdon Down, working on the same lines as Laycock, points out in "Mental Diseases of Childhood" the frequency of congenital ear deformities in idiots and the feeble-minded, associated often with webbed toes and fingers; also an implantation of the ears farther back than normally, giving an exaggerated facial development. In France, Italy, and Germany there has, within the last two or three years, sprung up a considerable literature on the subject, of which Frigerio's little book, "L'Oreille Externe Étude d'Anthropologie Criminelle" (Paris, 1888), is perhaps the most valuable. Dr. Frigerio, who has devoted special attention to this feature, both among criminals and the insane, finds certain peculiarities very common, and also notes various anomalies of movement in the pinna and its partial hyperæmia, especially in neurotic subjects. From the examination of several hundred subjects, he concludes that the auriculo-temporal angle (measured by a special otometer from the edge of pinna to the mastoid) undergoes a gradual progression from below 90° in the normal person, above 90° among criminals and the insane, up to above 100° among apes. He found the large angle very marked in homicides, less so in thieves. The longest ear Frigerio has ever seen in man or woman was in a woman convicted of complicity in the murder of her husband; the left ear was 78 *mm*, the right 81 *mm* (the normal being 50–60 *mm*) in length. Her father, her two sisters, and three cousins all possessed excessively large ears, and were all convicts. The degenerative variations to which he attributes most importance are the Darwinian tubercle, *i.e.*, a pointed projection in the outer margin of the ear,—frequent among the insane and criminals, the doubling of the posterior branch of the fork of the antihelix, and a conical tragus (very frequent in childhood and among apes) often found among the insane and criminals. Féré and Séglas,[2] who examined over 1,200 subjects—healthy, insane, idiot, and epileptic—found anomalies frequent among epileptics, and especially so among idiots, but not notably more frequent among the insane than among the sane. They especially noted the number of abnormalities frequently found in the same subject; and also a connection between defects in the ear and sexual abnormalities.

The most common (so-called) atavistic abnormalities of the ear—*i.e.*, those most frequently and prominently seen among the anthropoid and other apes—are the Darwinian tubercle,[3] absence of one of the branches of the fork, absence of helix, effacement of antihelix, exaggerated development of root of helix, absence of lobule. Adherent lobule may frequently be observed in well developed individuals; it is not found among apes, and appears to have no special significance.

The projecting ear has usually been considered as an atavistic character, and with considerable reason, as it is found in many apes, in some of the lower races, and it corresponds to the usual disposition of the ear in the fœtus. Marro prefers to regard it as a morbid character because it is so frequently united with true degenerative abnormalities, and because it is not always found in the lowest human races; Hartmann, for instance, having found it frequently among the European peasants, and in Africa more frequently among Turks, Greeks, and Maltese than among the indigenous fellaheen, Berbers, and negroes of the Soudan. Among so low a race as the Australians the ear is often, I have noticed, very well shaped. At the same time the projecting ear frequently accompanies deaf-mutism, Dr. Albertotti having found it in sixteen out of thirty-three deaf-mutes.

The ear, it is well-known, is very sensitive to vaso-motor changes, slight changes

[1] "Lectures on Physiognomical Diagnosis of Disease," *Medical Times*, 1862.

[2] "Contributions à l'Étude de quelques Variétés Morphologiques de l'Oreille Humaine." *Revue d'Anthropologie*, April 15, 1886.

[3] Schwalbe, who distinguishes five principal forms of the Darwinian tubercle, regards it as normal, and believes that with a little practice it might be discovered in nearly all ears. This may well be, but in its distinctly marked form it can scarcely be called normal.

serving to affect the circulation visibly; so that in pale, nervous people a trifling emotion will cause the ears to blush. Galton tells us of a school-mistress who judges of the fatigue of her pupils by the condition of their ears. If the ears are white, flabby, and pendant, she concludes that the children are very fatigued; if they are relaxed but red, that they are suffering, not from overwork, but from a struggle with their nervous system, rarely under control at the age of fourteen or fifteen. If this kind of sensitiveness is not common among criminals, a few of neurotic temperament, as well as some lunatics, possess the power, rare among normal persons, of moving the ear. Frigerio notes movements of the superior and posterior muscles, especially when touched; in apes the transverse muscle also acts. Frigerio connects this power of movement with perpetual fear, always on the look-out; many of the criminals with this peculiarity were recidivists, and three of the lunatics had delusions of persecution.

The interest of these investigations, now so actively carried on, into the malformations of the pinna among criminals is obvious. A few ingenious persons have sought to explain some of them by the influence of the headgear, pulling of the ears, etc.; but on the whole it is generally recognized that they are congenital. The study of them, therefore, is of distinct value in enabling us to fix the natural relationships of the criminal man. There is still need for careful series of observations on criminals, the insane, epileptics, and idiots, and every such series should be controlled by a similar series of observations, by the same observer on ordinary subjects.—*Lancet*, Jan. 25, 1890.

Folsom (C. H.) on Insomnia.—Examination of his cases showed the following causes: 1. Perverse habits. 2. External causes, including sensations, habit, heat, cold, hunger, noise, etc. 3. Excessive intellectual or mental activity, including excitement, grief, fear, etc. 4. Reflexes, of which indigestion was far the most common. This might fail to be indicated in the usual ways; next genito-urinary reflexes. 5. Traumatic causes. 6. Autotoxic, in acute diseases, rheumatism, malaria, nephritis, constipation, excessive use of tea, bromides, etc. 7. Exhaustion from wasting diseases, sexual excesses, impaired nutrition of the brain. 8. Insomnia of vascular origin, from hepatic, cardiac, and renal disease, cerebral hyperæmia, arterial sclerosis, in syphilis, during puberty, menopause, etc. 9. Vaso-motor causes. 10. The neuropathic temperament, usually inherited, sometimes acquired. 11. Other diseases, as hysteria, hypochondria, organic diseases of the brain, etc.

The treatment related to change of habit, hygienic conditions, change of place, use of drugs, but hypnotics required to be given with care, and with the fact in mind that their long-continued use might be injurious or dangerous.—*Med. Record*, May 24, 1890.

Sharp (L. N.) on a Case of Somnolence.—On March 3d last I was asked to see an old lady, eighty-two years of age, who had enjoyed good health and carried a considerable amount of flesh. She had an attack, about ten days before, of what I considered the passage of a gall-stone, during which she was cared for by another physician.

When I first saw her she was comfortable, lying in bed, pulse 90, tongue clean, and temperature normal. The following day when I made my visit to her she was sleeping, and as this was quite late in the day, and she had slept all the time since I had seen her the day before, I feared she had been taking some narcotic, but of this there was no other evidence, save sleep. I saw her day after day for three weeks, during which time she continued to sleep day and night, constantly, only when awakened to take some liquid nourishment and then she would, perhaps, partly answer a question and fall into a sweet and apparently pleasant sleep. No abnormal condition appeared present otherwise. When the second week came on I thought she could be aroused more readily, and at the end of the third week she could be kept awake by talking with her for perhaps an hour at a time, in the afternoon only. From this time on she gradually slept less and soon gained strength, her appetite returned, and she was, in a short time, around the house as usual.

During this time of sleep the pulse and temperature remained normal. The urine was voided part of the time without her knowledge, but generally she manifested uneasiness, and her attendants would use the bed-pan. The bowels did not move till about the close of the third week, and then the passage was not formed. She

had been freely purged before I saw her. When she came out of her sleep she was impressed that she was in hospital, and could not reconcile her surroundings with what she was accustomed to, while she had occupied the room in which she had slept for a long time in the house of her daughter. No other delusion or any indication of cerebral trouble was manifest.—*Med. Record*, June 14, 1890.

Actinomycosis Attacking the Brain.—The lung is the organ most generally attacked, and cases of actinomycosis attacking the brain are extremely rare, only six cases being on record. In the *Deutsche medicinische Wochenschrift*, No. 16, an interesting case of this kind is reported by Dr. Orlow. The patient was a woman aged thirty, who was first seen in December, 1887, with the history of having been ill for one year, her illness commencing with a swelling on the left side of the neck, followed by other painful tumors over the large trochanter and tibio-tarsal joint; she also suffered from right-sided pleurisy. On admission to the hospital several small abscesses were found over the above-mentioned localities, as well as over the upper part of the right arm, and in the pus obtained from these abscesses characteristic actinomycotic granules were discovered. On January 22, 1888, the patient was seized with vertigo, and spasmodic contraction of the fingers of the right hand. Similar attacks occurred on the following days, the contractions gradually passing upwards until the face muscles were also affected; the patient vomited frequently, and as the attacks increased in extent loss of consciousness became more and more complete. She continued in much the same condition for a month, at times showing some slight improvement. At the end of this time, however, the right arm became paralyzed, followed by loss of power in the right leg and loss of sensation down the right side. The convulsive seizures gradually grew more severe, and passed over to the left side. The patient gradually sank, and died on March 7th. The symptoms pointed to some cortical affection, and this proved to be the case, for at the necropsy, in addition to the superficial abscesses already mentioned, an abscess was found in the left hemisphere of the brain, situated immediately below the membranes, and involving the ascending frontal and ascending parietal convolutions. The pus from this abscess contained actinomycotic granules. The right lung was also affected but the other organs were healthy. This is the first recorded case in which actinomycosis attacking the brain produced such pronounced motor and sensory phenomena, and is consequently especially interesting from a clinical point of view.—*Lancet*, May 17, 1890.

Sinkler (W.). Recent Observations in the Etiology and Treatment of Migraine.—This disorder was more common among the wealthier classes than the poor, and it occurred at all ages. It was due to reflex causes, chief of which were uterine diseases, eye-strain, over-use, astigmatism, etc., nasal irritation, enlarged tonsils, and bad teeth. The attacks often recur on the same day of the week, explained in many cases by the diet or duties of the preceding day.

In treatment, the condition of the system should receive attention. Local troubles should be treated as each might demand. For the eyes, suitable glasses were needed and rest. Bicarbonate of soda and cocaine, applied to the pulp of a carious tooth, would relieve migraine due to that cause. When the source of irritation was in the nose, the headache was very apt to be frontal. Post-nasal catarrh was frequently to be treated in young children suffering from headaches.

Antipyrine, phenacetine, eucalyptus and caffeine had been used with much success the past few years. He preferred to employ large doses at first, and diminish afterwards. Of antipyrine, he gave fifteen to twenty grains at first. Phenacetine was better than antipyrine, in that it was less depressing in its action on the heart than the latter. Cannabis indica was of great value in many cases. It should be given for a considerable time, and the dose increased until slight toxic symptoms appeared. Hypnotism or post-hypnotic suggestion worked well in some cases. A change of scene or climate occasionally worked wonders.—*Boston Med. and Surg. Jour.*, May 29, 1890.

Gill (S. A.) on the Toxic Insanity, Especially in Relation to Chronic Alcoholism.—The treatment may be considered under the following headings: hygienic, dietetic, and medicinal. The hygienic treatment should be moral and physical. Moral treatment consists really in teaching the patient self-control over his

passions and appetites. But how is this to be done? I answer, by the force of example. By placing over the insane mind a sane mind, combined with firmness, gentleness, and kindness. Physical treatment will of course depend upon the bodily condition of the patient, and consists in keeping the mind occupied as much as possible by some healthy recreation, by daily exercise in the fresh air, or even by manual labor, provided he is fit for it. No matter, however, what the condition is, I am convinced that these patients should spend most of their existence out-of-doors, fresh air being both a tonic and a sedative to the nervous system. Under this *régime* they eat well, sleep well, and gain in weight. So far as medicinal treatment is concerned, attention must be paid to the digestive functions by mild saline purgation, or aloes, and by the exhibition of stomachic tonics, such as mineral acids, and bitter infusions. I have found of great service a pill containing phosphorus and strychnine, of each $\frac{1}{30}$ of a grain, three times daily, between meals, especially where there are muscular cramps and spasms. Narcotics should be avoided as much as possible. The basis of all treatment should be fresh air, good food, and skilled nursing.—*Med. Press*, May 21, 1890.

Dangers of Hypnotism.—Hypnotism is apt to be a dangerous mental poison, and as such it needs to be fenced round with as many restrictions as the traffic in other kinds of poison. Narcotics of any kind are not to be handled by the ignorant, and are liable to reckless abuse by the feeble in mind or body.—*Brit. Med. Jour.*, May 31, 1890.

Crothers (T. D.) on Alcoholic Trance in Criminal Cases.—The author says: 1st. The trance state in inebriety is a distinct brain condition, that exists beyond all question or doubt.

2d. This brain state is one in which all memory and consciousness of acts or words are suspended, the person going about automatically, giving little or no evidence of his real condition.

3d. The higher brain-centres controlling consciousness are suspended, as in the somnambulistic or hypnotic state. The duration of this state may be from a few moments to several days, and the person at this time may appear conscious and act naturally, and along the line of his ordinary life.

4th. During this trance period crime against person or property may be committed without any motive or apparent plan, usually unforeseen and unexpected. When accurately studied such a crime will lack in the details and methods of execution, and also show want of consciousness of the nature and results of such acts.

5th. When this condition passes away the acts and conduct of the person show that he did not remember what he had done before. Hence his denial of all recollection of past events, and his changed manner confirm or deny his statements.

6th. When such cases come under judicial inquiry the statement of the prisoner requires a scientific study before it can be accepted as a probable fact. It cannot be simulated, but is susceptible of proof beyond the comprehension of the prisoner.

7th. In such a state crime and criminal impulses are the result of unknown and unforeseen influences, and the person in this condition is dangerous and an irresponsible madman.

8th. This condition should be fully recognized by court and jury, and the measure of responsibility and punishment suited to each case. They should not be punished as criminals, nor should they be liberated as sane men. They should be housed and confined in hospitals.—*Jr. Am. Med. Assn.*, April 5, 1890.

Dana (C. L.) on a Study of Alcoholism as it Occurs in the Bellevue Hospital "Cells."—The treatment as at present carried out in my term of service, is about as follows: The patients when they first come in are given a cathartic and ordered a diet of milk and beef-tea. If they reject food, they are given powders of bismuth and capsicum or rhubarb and soda. Alcohol is at once stopped, unless there are complications, such as pneumonia. In the milder cases they are put upon a mixture of bromide and chloral, with sometimes paraldehyde, taken every two hours till sleep results. If this is inefficacious, a hypodermic injection of morphine and hyoscyamine is given, and this is usually sufficient. Hyoscyamine alone is not a good drug, but with the morphine it seems to act well. If it were practicable, the patient would be placed on a large mattress in a padded room and left unrestrained, or else put in such an apparatus as Magnan's jacket, which allows of some movement and does not impede respiration.

As it is, we have to tie most patients down, as otherwise they tear their clothes off and destroy the bedding. The women are usually more easily controlled than the men, for they have not been able to get so much liquor into them. Despite all that can be done, the patient will sometimes not sleep, or, if he does, the sleep is only a narcotism, from which he awakes without being refreshed; the delirium continues and death ensues from exhaustion.—*N. Y. Med. Jour.*, June 14, 1890.

[It may have been an omission on the part of the writer, but we are surprised to see no mention of digitalis, which we consider the most important remedy in acute or chronic alcoholism.—Ed.]

Buzzard (T.) on Vertigo of Bulbar Origin.—With regard to the treatment of the affection the author says: My impression, however, has long been, that in a large number—perhaps the majority of cases of auditory nerve vertigo—it is through its centre in the medulla oblongata that the nerve is affected, and not at its periphery.

Many years since I brought forward clinical evidence which appeared to show that uric-acid salts by their presence in lymph spaces might produce symptoms of sciatica and infantile paralysis. I would only now suggest that a like source of irritation of nerve nuclei in the bulb is conceivable in connection with the lymph spaces in the walls of the blood-vessels, but this is necessarily hypothetical.

It has long been my habit to prescribe salicylate of sodium in cases of vertigo associated with auditory nerve symptoms. The employment suggested itself partly on account of its elimination of uric acid, and partly also because it apparently exerts some direct influence upon centres in the medulla oblongata, occasioning, as it does in full doses, reduction of temperature, headache, deafness, tinnitus aurium, giddiness, and sometimes dangerous depression of the heart's action.—*Lancet*, Jan. 25, 1890.

Money (A.) on Ménière's Disease (Aural Giddiness) Provoked by Influenza.—A man aged thirty-four, of neurotic type, came to me complaining that since an attack of influenza in January last he had become subject to attacks of giddiness, commencing with a sudden loud noise in the right ear. There appears to be no nystagmus, and only once has he noticed nausea or sweating. On referring to my notes, I find that he was a little deaf in the right ear in 1883, and that he at times noted a loud report (subjective) in the right ear, but that there was no sensation of movement in any direction. There is no evidence of disease of the middle ear or Eustachian tube.

It is, I believe, a frequent occurrence for influenza to damage the balancing nervous apparatus; here it is out of place to discuss the part of the apparatus spoilt; the most likely suggestion is an effusion into one semicircular canal, but which one I cannot make out. Nor is this suggestion free from objections. Salicine and antipyrine are the drugs being employed with partial success. The number of attacks was more than a dozen a day at first; now he may go a day without an attack, and generally does not have more than three or four, but the giddiness is great enough to require the recumbent posture, but not great enough to cause vomiting, sweating, tingling, or loss of consciousness. Perhaps it is not right to speak of degree of giddiness as capable of provoking such symptoms; it may be that the *direction of the nervous discharge* determines these symptoms, just as in the case of epilepsy it seems to be a peculiarity for the nervous discharge to cause vomiting, micturition, and defecation. Dr. Owen clearly pointed this out.—*Lancet*, May 3, 1890.

Norman (C.) on Acute Confusional Insanity.—This form of psychoneurosis occupies an intermediate place between acute mania and the acute dementia of the older classificatory schemes, and contained a very large number of cases. It was characterized by engagement of consciousness in the form of dream-like confusion, together with hallucinatory disturbance. Puerperal, post-febrile, rheumatic, phthisical, and other varieties of insanity depending on general diseases, commonly took this form. Mr. Norman dwells upon its frequency in alcoholic cases.—*Brit. Med. Jour.*, June 28, 1890.

Sudden Death in Psychoses.—In an address at the annual meeting of Alienist Physicians, Dr. Brie, of Bonn, discussed this subject of sudden death taking place in lunatics, where disease had not been previously suspected. In four cases, marked disease of the cardiac muscular structure was demonstrable in the form of advanced fatty degeneration, with some

arterio-sclerosis of the coronary artery in two cases. Myocarditic processes, with hypertrophy of the heart in the two others, and in all atheromatous degeneration of the aorta. Regarding the explanation of these degenerations he looks upon them as an expression of permanent trophic disturbances of innervation, and dependent on the cerebral disease that is the foundation of the psychosis, *i. e.*, provided there are no other more evident causes to which the changes can be referred.—*Med. Press*, Jan. 29, 1890.

Periodical Insanity of an Epileptic Nature.—A boy, aged fourteen, suffered from periodical attacks of insanity. About two years ago he was struck on the nose, and about two weeks later he began to have attacks of great irritability, and was sent to an asylum, where he remained twelve months. Before he came under Dr. Suckling's notice he used to have an attack regularly every month. Each attack was made up of eight or nine separate attacks, the boy being quite well in the interval, and the whole attack would last two or three days, the attacks being grouped like those of ordinary epilepsy. At first he lost consciousness in the attacks, but he did not do so now; there had never been any convulsion or involuntary micturition, and he had never bitten his tongue. He could tell when the attacks were coming on by a feeling of numbness and giddiness, drowsiness and numbness, with dreams, preceding the attacks. During the attacks he was stupid and very irritable. He cried out and complained of heaviness over his forehead. Dr. Suckling considered the case analogous to motor and sensory Jacksonian epilepsy, probably depending on injury to the frontal lobes. Smell and taste were unaffected, and there was no optic neuritis.—*Brit. Med. Jour.*, April 26, 1890.

Carter (G.), on Landry's Paralysis.—After describing a non-fatal case of the disease, the author says: Of the pathology of this disease we know but little. Baztian's definition of it is: "A mysterious affection of the spinal cord, first definitely described by Landry in 1859, characterized on its clinical side by the existence of a progressive paralysis, advancing rapidly from below upwards, and characterized on its anatomical side by the most puzzling absence of an appreciable pathological change. On account of the latter peculiarity the disease ought really to be described under the class of those dependent upon unknown or imperfectly known organic changes. It would appear that we have to do with a simple alteration of the molecular condition of the spinal motor nerve centres, unaccompanied by any known inflammation or irregularity of vascular supply."

To these words I have nothing of my own to add, but I know it has been more recently suggested by some writers—with what show of truth and accuracy of observation I will ask you to judge and, if you will, comment upon—that Landry's paralysis is due to chill, causing an effusion of fluid in the central canal of the spinal cord, this fluid rising higher and higher, and exerting most pressure where the column of it is deepest and heaviest—that is, from below upwards—until finally the ventricle of the medulla is reached, and such symptoms as I have described to you are held to supervene.—*Brit. Med. Jour.*, May 17, 1890.

Locomotor Ataxy: Symptoms Suddenly Developed after an Injury.—A man, æt. 44, three months ago fell into a hole about six feet deep, coming down upon his feet. He did not feel at all injured, but two days afterwards he felt a severe pain in the back, which lasted two days, and was immediately followed by severe vomiting at short intervals for six days; then the gait became unsteady, and numbness in his feet and fingers was perceived; no pain nor interference with sphincters of rectum or bladder; no history of syphilis. On admission three months after the accident, the patellar reflex was found to be absent, and there was great wavering of the limbs on an attempt to stand upright with the eyes shut; gait is decidedly ataxic; never had any lightning pains. After a month's stay in hospital there was considerable improvement showing itself by an almost entire loss of the numbness and by a much improved gait, but after spending three weeks at his home, the numb sensations returned and the unsteadiness increased. On readmission, it was found that the gait was steadier than when he left, but there was no change in the knee-reflex phenomenon. Neuro-retinitis present in both eyes.—*Montreal Med. Jour.*, Jan., 1890.

Thompson (C.M.) on Sudden Paraplegia from Syphilitic Disease.—The patient was a native policeman, aged 24, who was in his usual health when

relieved from duty at 6 P. M., on November 6th. At 10 P. M., while on his way to reserve duty, he stooped, and as he bent "felt something crack in his back." He was found lying on the road unconscious, and was admitted into hospital at midnight. When examined on the following morning he was drowsy, but could be aroused to answer questions; the pupils did not respond to light. Respiration was entirely diaphragmatic. There was anæsthesia from the upper margin of the fourth rib downwards, and complete paralysis of the lower limbs; the penis was semi-erect, and the bladder distended; he had partial loss of power in both arms; he could just move them with a good deal of difficulty, sensation on the upper part of the thorax and in both upper extremities was unimpaired. The respirations were shallow and very much labored, 28 per minute; the pulse was full and strong, 80 per minute. There was no sign of injury. At the back of the neck, from a point corresponding to the sixth cervical vertebra to the middle of the back corresponding to the eighth dorsal vertebra, there was pain on deep pressure. The pain on pressure was most severe at a point corresponding to the seventh cervical vertebra. There was the cicatrix of an old chancre on the penis, and the glands in both groins were enlarged. He was a remarkably well-developed, muscular man, with a capacious chest. The temperature was 100° F. The patient rapidly grew worse, and died on November 15th. At the necropsy, which was made about 2½ hours after death, no abnormality was detected in the brain, except that the pia mater was adherent to its surface along the upper margin of both hemispheres. The spinal cord was carefully removed. Opposite the fifth cervical vertebra was a spot of softening of the cord, the area of softening extending for about half an inch; the upper margin corresponded with the level of the fifth cervical nerve. In the lumbar region of the cord was a spot of softening similar to that found in the cervical region; its upper margin was on a level with the tenth dorsal nerve, and from this point the softening extended for about one inch and a quarter. The dura mater was not abnormally adherent to the cord in this or any other part. On dividing the cord vertically downwards, there was found in the cervical region a circular cavity, a quarter of an inch in diameter, involving almost the entire thickness of the cord, and corresponding with the area of softening, and containing a thick creamy fluid. Corresponding to the area of the lumbar softening, there was a cavity presenting similar appearances, the long diameter of which was in line with the axis of the cord. With the above-mentioned exceptions, the nervous tissues of the cord and its membranes appeared to be perfectly healthy.—*Brit. Med. Jour.*, June 14, 1890.

OCCASIONAL REPORT ON DISEASES OF THE EYE.

De Schweinitz (G. E.) on the Ocular Complications of Malaria.—According to the author malaria may originate:

1. An ophthalmia of the intermittent type, which sometimes replaces the ordinary manifestations of the disease.

2. A form of keratitis, properly described as "malarial keratitis," and quite distinct from those types of corneal inflammation which are simply associated with intermittent fever.

3. Various functional ocular disturbances, amblyopia, paresis of accommodation, changes in the field of vision, even hemianopsia and night blindness.

4. Gross changes in the interior of the eye, optic neuritis, optic atrophy, retinal hemorrhages, and hemorrhage into the vitreous.

In the event of the appearance of any of the disorders of the fourth class, it is necessary, before ascribing it to malaria, to eliminate rheumatism, syphilis, chronic Bright's disease, and chronic hepatitis; and, in so far as atrophies are concerned, the influence of quinine. In any doubtful case, especially in larvate forms of intermittents, and, indeed, in all cases, a careful examination of the blood should be made with the hope of determining the presence or absence of the corpuscles of Laveran. It remains to be shown what relation the character and number of these bodies bear to ocular diseases attributed to malaria.—*Med. News*, June 7, 1890.

Claiborne (J. H.) on Pink-Eye.—According to the author:

1. Pink-eye is an acute catarrhal disease of the conjunctiva.

2. It is usually infectious, always contagious, sometimes sporadic.

3. The cause is undetermined, but is

evidently an entity transmissible through the air and communicable by contact.

4. The prognosis is good.

5. Duration : four to six weeks.

6. Treatment : cold, antiseptics, of which the best is borax, mild astringents, and bland salves.—*N. Y. Med. Journal*, June 28, 1890.

Galezowski on Epithelioma of the Cornea.—The first symptoms of epithelioma of the cornea are manifested by a circumcorneal injection accompanied with some pain ; then the surface of the cornea is seen to be irregular, but the tissue proper of the membrane does not alter much for several months, even in some cases for several years. The tumor as it grows exhibits an irregular shaped appearance, and ultimately causes some swelling of the lids. Sometimes it penetrates into the anterior chamber, and may even cause destruction of the globe. Under these circumstances of its development, the cornea becomes thickened from hypertrophy of its interstitial tissue. Galezowski recommends especially the use of the galvano-cautery for the removal of the tumor. In several cases where excision by means of the bistoury had failed, the application of the galvano-cautery has prevented recurrence.—*Med. Press*, Feb. 5, 1890.

Intra-Ocular Symptoms Due to Nasal Disease.—According to an article in the *Berliner klinische Wochenschrift*, an abstract of which appears in the *Centralblatt für klinische Medicin*, Ziem found that the field of vision was cut off to a greater or less degree in seven cases of suppuration in the antrum of Highmore, and that treatment directed to the nasal trouble was followed by immediate and marked improvement, not only in the field, but also in the acuteness of vision and in the strength of accommodation. In two cases he noticed changes in the refraction during the treatment. Examination of the eyes revealed nothing except venous hyperæmia of the papillæ. Ziem does not consider that these are reflex symptoms, but that they are due to venous pressure in the ciliary region, caused by the interference with the venous circulation in the nose.—*N. Y. Med. Journal*, May 31, 1890.

Berry (G. A.) on Removal of Foreign Body from Orbit.—The day before admission to hospital the patient was struck on the eye by a man's fist holding an ordinary clay pipe. There was a wound of the lower lid, from which some fragments of clay were removed. It was not supposed at that time that any part of the pipe had entered the orbit. After a few days, Mr. Berry, suspecting an abscess was forming, enlarged the wound and passed in a probe, which immediately revealed the presence of a foreign body situated about an inch from the surface. The wound had to be still further enlarged, and the insertion of several of the ocular muscles severed before the foreign body could be removed, which proved to be a piece of the stem of the clay pipe, and was nearly two inches in length. The wound healed without any suppuration, and now, a month after operation, the sight of the eye is as good as it was before the accident occurred. The patient was not aware of the presence of the foreign body, and it was also curious that the pipe-stem should have penetrated so deeply without doing more injury.—*Med. Press*, June 11, 1890.

Heyl (A. G.) on the Treatment of Hypopion Keratitis. — A man, aged thirty, came with a slight central ulcer of the cornea, which had been under treatment for about a month without success. The case was evidently one of hypopion ulcer, and the local application of iodoform salve, grains x., to the drachm, soon healed it. Some nine months later the patient presented himself with a fresh ulcer in the same spot, and this time the iodoform salve failed to bring about any material result. The nasal passages were then examined, and an offensive rhinitis found. Applications of iodoform were made to the nasal mucous membrane, as well as to the corneal ulcer, and the latter at once began to heal. The lessons involved in this experience are, that when the infecting focus is in the nose in cases of mycotic corneal ulcers, it is not always sufficient to treat the corneal disease, but the nasal mucous membrane must be treated at the same time ; and further, that a recurrence of the corneal ulcer is possible, if the nasal disease is allowed to remain unhealed. This experience also emphasizes the importance, in all operations which involve the removal of, or cutting through, the corneal epithelium, of seeing well to the condition of the nasal mucous membrane. It can scarcely be doubted that the microbe of the hypopion ulcer is harmless in the conjunctival sac, so long as the sclero-corneal epithelium is intact ;

but let a small abrasion occur in the latter, and infection at once takes place. Hence, in cataract extraction, it is a good prophylactic measure not only to make iodoform applications to the conjunctival sac, but also to the nasal mucous membrane. So far as my present knowledge goes, suppurative keratitis after cataract extraction is mycotic, and in a large majority of cases the infection is derived from the lachrymal sac; and practical experience seems to show that under such circumstances solutions of bichloride or boric acid are useless, and iodoform the proper agent. — *Am. Lancet*, June, 1890.

Williams (A. D.) on the Removal of Lead Deposits from the Cornea.—Lead deposits in the cornea are easiest and best removed by scratching the half-dead white tissue, saturated with lead, completely off with a suitable instrument. In this case I used the point of a knife, and scratched back and forth till all the whitened tissue came away. The half-dead tissue easily separated from the healthy corneal substance below, leaving the bottom an open depression, thus made transparent—black. This is proof that the lead deposit has all been removed. In this case more than half of the thickness of the cornea was scratched away. It is important to scratch the edges of the lead deposit away as perfectly as possible. The scratching caused considerable bleeding. Now there is an open sore or ulcer, which nature must heal. There being nothing to prevent it, the healing process will go on rapidly under the usual treatment with atropine, and in the course of a few days the eyes will cease to be painful. Then the pannus will need the usual treatment. In such cases the removal of the lead deposit is an absolute necessity. Without that it is impossible to stop the pain, relieve the irritability, and cure the pannus.—*St. Louis Med. and Surg. Jour.*, July, 1890.

Davidson (McK.) on Micro-Corneæ.—A man, aged thirty-four years, was the subject of this condition. Both corneæ were very small, six millimetres in diameter. There was a coloboma of iris and choroid in both eyes downwards and inwards. The eyeballs, as a whole, were small, the left the smaller, with vision restricted to hand movements. Details of the fundus could not be made out. On the right, vision was sufficient to enable the patient to walk without difficulty. The lens, apparently of full size and quite transparent, was dislocated downwards and inwards, and lay over the coloboma of the choroid, probably the result of a blow on the right eye in September last. The movements of the eyeballs were also imperfect, both being in a state of habitual convergence. There was also very rapid lateral nystagmus. No family history to account for the man's defective sight could be elicited.—*Brit. Med. Jour.*, May 3, 1890.

Ledbetter (S. L.) on the Treatment of Corneal Ulcers.—Constitutional and constructive treatment, when necessary, and local treatment, as follows: In phlyctenular ulcers, hot fomentations, belladonna, and the actual cautery or thermocautery, when the eye is very irritable with considerable photophobia and ciliary irritation, and in the later stage, where stimulation is indicated, calomel, or the application of mercury in the form of an ointment. Superficial ulcers from any other cause treated similarly; when any indication of sepsis exists, the free use of the actual cautery, galvano-cautery, scraping, and the free use of antiseptic lotions. In deep ulcers, the sheet anchor is tapping or paracentesis to relieve the tension and nervous irritability of the cornea to prevent staphyloma and iritic adhesions; to let out pus when it exists, and in cases where stimulation is specially indicated, Saemisch's operation.

In the treatment of serpiginous ulcers, the use of the cautery and germicides; puncturing the cornea when necessary and washing out the anterior chamber with antiseptic washes to destroy points of infection which might exist in Descemet's membrane.—*New Orleans Med. and Surg. Jour.*, 1890.

Kipp (C. J.) on Gonorrhoic Irido-Choroiditis.—In the treatment of this affection I have at various times employed nearly all the remedies that have been suggested for inflammation of the uveal tract. Instillations of a strong solution of the sulphate of atropine and of the muriate of cocaine were, of course, made frequently from the day the case came under treatment till all inflammatory symptoms had disappeared. In only a few cases were cold applications to the lids of any benefit, while, on the other hand, warm formentations seemed to soothe the eye. For the relief of the excessive pain which was pres-

ent during the first week of the disease I have applied from six to twelve leeches to the temple, and have given internally the salicylate of sodium in twenty-grain doses every two hours till the physiological effects of this drug were produced; after that it was used in smaller doses at longer intervals. Not unfrequently it was necessary to give in addition morphine or antipyrine at night in order to procure sleep. Quinine in large doses was given occasionally to patients who could not take the salicylate of sodium, and in some cases with apparent benefit. In former years I gave in such cases calomel and other preparations of mercury, but have abandoned this treatment, as the remedies above-mentioned seem to give more speedy relief. After the subsidence of the pain I have given the iodide of potassium or the muriate of pilocarpin with a view of clearing up the vitreous body, and this was usually accomplished in the course of some months.—*Med. Record*, July 12, 1890.

Andrews (J. A.) on the Treatment of Purulent Ophthalmia.—Put patient to bed. Protect the healthy eye if there be one, and begin cold applications at once.

In my experience, the intelligent use of a two-per-cent. solution of nitrate of silver yields the best results in the treatment of purulent ophthalmia. A solution of carbolic acid (1 to 1,000) for washing the eye is also regarded as a useful adjuvant. But a saturated solution of boric acid is antiseptic and astringent, and practically preferable to either corrosive sublimate or carbolic acid.

The active symptoms may last for three weeks. During this period the cornea must be closely watched. Remember this very important fact—viz., the cornea is not necessarily out of danger because the more acute inflammatory symptoms of the disease have subsided. Perforation of the cornea and loss of the eye may occur in some exceptional cases after the disease seems far advanced toward recovery. I never have had occasion to use the nitrate of silver after the fourth week of the disease. Generally before this the disease has passed into a condition when active remedies actually retard the recovery. I am in the habit, at this period, of keeping the eye clean with a three-per-cent. solution of boric acid and of applying vaseline between the eyelids.—*N. Y. Med. Jour.*, June 21, 1890.

Wylie (D. B.) on Hypermetropic Astigmatism and its Relation to "Nervous Sick Headache."—The case narrated by the author is interesting, from the fact that while great relief followed a partial correction of the error of refraction, complete cure did not supervene as long as one quarter of a dioptric remained uncorrected.—*Memphis Med. Mo.*, Jan., 1890.

Bowker (J. C.) on Traumatic Iridodialysis.—The patient, a highly intelligent lad of eight years, was playing with his comrades when he felt something strike his left eye, followed by a sharp pain. He was immediately seen by a physician, who prescribed for him and sent him home. Two days later the father took the case into his own hands, and, in examining the eye, found a leaden bullet, weighing eight and a half grains, snugly packed away between the ocular and palpebral conjunctivæ, at the external canthus. This was removed, and when the boy was brought to me there was but a slight conjunctivitis, ciliary injection, and photophobia, together with a rent in the iris, covering probably five or six square millimetres, through which the red reflex was visible. The rupture was at the inferior external quadrant and about two millimetres of the ragged edge of the iris remained along the ciliary margin. The contraction of the iris threw the normal pupil into an irregular oval shape. Vision in the affected eye was 0.6, but through the artificial pupil light alone was distinguishable. The cornea was entirely uninjured and no abrasion could be detected even with a high-power lens. Though the false pupil still exists, the troublesome symptoms have, under treatment, wholly disappeared. The fundus is normal, the capsule seems unaffected, and the lad suffers almost no inconvenience, save from the disfigurement, which is slight.—*Med. Record*, Jan. 25, 1890.

Smith (P.) on Tobacco Amblyopia in a Woman.—The patient, a very respectable-looking middle-aged woman, had taken to tobacco smoking two years previously, under the advice of a medical man, for the relief of asthma. She liked it and had smoked about four pipes a day since then. She was a small eater, a poor sleeper, and had had many domestic troubles. The speaker explained how, in a case of this kind, the diagnosis could be made with considerable certainty before the question as to tobacco was asked. He referred to

the very frequent history of mental worries and troubles in cases of tobacco amblyopia, the depression of the system arising from which rendered it more liable to poisoning by tobacco. If women generally were to become habitual smokers, they would be very prone, among the lower classes, to tobacco amblyopia; for among the poor the women suffered more than the men from insufficient food, loss of sleep, and domestic troubles.—Mr. Eales has seen some six or eight cases of tobacco amblyopia in women. Personal idiosyncrasy was largely answerable for its occurrence, but he thought increasing years or ill-health were generally important predisposing factors. Some twelve years ago, he found this amblyopia in a woman, aged thirty-eight, who smoked and chewed tobacco to excess, besides taking snuff. She was also a heavy drinker. In eight weeks her vision recovered from being $\frac{20}{200}$ = to normal ($\frac{20}{20}$) without any treatment, on merely discontinuing tobacco, though she did not abstain from alcohol. In one case he had seen, the patient admitted having smoked two pounds of Cope's mixture and a few cigars in eleven days previous to the failure of vision: on the other hand, he had seen this affection in an old man who only smoked an ounce of tobacco weekly.—*Brit. Med. Jour.*, Apr. 26, 1890.

Tight Collars and Vision.—The influence of tight collars in impeding the circulation in the head by pressing on the jugular veins is well-known to military surgeons with the troops in India; but the bad effects of such pressure in cooler climates has been demonstrated by the observations of Prof. Förster of Breslau, who states that 300 cases have come under his notice in which the eyesight has been affected by the disturbance of the circulation caused by wearing collars that were too small. A large number of these cases were probably subjects of myopia.—*Lancet*, Feb. 1, 1890.

Gifford (H.) on Embolus of a Branch of the Retinal Artery, Visible with the Ophthalmoscope; Disappearance of the Embolus and Nearly Complete Recovery under Massage and Nitrite of Amyl.—On February 27, 1889, I was called to see Mr. C., æt. 29. He stated that about half an hour before, while at breakfast, the right eye suddenly became blind. In a few moments, however, on rubbing the eye and applying hot water, the field cleared up, partly, below, and then remained stationary until my arrival. The eye was found normal externally, but the ophthalmoscope showed the lower branch of the retinal artery to be filled with a whitish plug, from a point just back of the surface of the disc to about one millimetre beyond its border. The plugged portion of the artery seemed of normal calibre and was of a dead yellowish-white color. Peripheral to the clot, the calibre was not perceptibly reduced, but the vessel had the color and appearance of a vein. A rough test of the field showed the absence of the entire upper half and of the contiguous 20°–30° at the nasal side. Having no test-types with me, the vision was not accurately tested. The eyeball was at once massaged vigorously for two or three minutes, without immediate effect. The patient was then directed to massage the ball for two minutes every half hour, and to inhale 5 minims of nitrite of amyl every three hours.

At 3 P.M. of the same day the patient was seen again and reported a decided improvement. An examination showed no positive trace of the former clot; all the arteries looked normal with the possible exception of a slight thickening at one point of the wall of the lower branch, which may perhaps have been an adherent remnant of the plug. Unfortunately I neglected to examine the periphery with minute care in the direct method, but an ordinary examination showed no traces of bits of the plug impacted in this region, nor did a more careful examination on the succeeding day. The field now, about seven hours after the occurrence of the embolism, was found to be entirely restored in about 50° at the temporal side, the area corresponding to that part of the retina supplied by the median artery.

The remainder of the upper half of the field lacked between 10° and 20° at the periphery, this blank being followed by a zone about 20° wide in which objects were seen dimly; followed in the upper nasal quadrant by a sector-like scotoma, with a very irregular border at the temporal side, reaching down close to the point of fixation. V. = $\frac{1}{10}$. The patient had already inhaled two five-minim perls of the nitrate of amyl, and was ordered one more that day and two more the next forenoon; the massage being discontinued. The next afternoon the field was somewhat further improved and the dim area clearer. The

retinal arteries appeared normal throughout, pulsating well on pressure on the globe; but to my surprise the characteristic œdema of the retina was well marked toward the centre of the fundus, in the temporal ¼ of the lower half of the retina.

No further treatment was given and the condition slowly improved till, on May 2d, two months after the embolism occurred, with a normal fundus, the nasal two-thirds of the upper half of the field was contracted about 10° at the periphery and showed two small scotomata in the nasal quadrant with—0.5c ax. 180°, V. = ⅓ in each eye. With regard to the etiology, the case gave no satisfaction. The patient was somewhat run down with overwork, but aside from a chronic purulent otitis in the right side, was in good health. No evidence of kidney nor heart trouble.—*Jour. Am. Med. Ass'n.*, April 12, 1890.

Chisolm (J. J.) on the After-Treatment of Cataract Patients.—He does not put his patients, after cataract operation, in dark rooms. He does not treat them in bed. He does not bind up the eyes. He does not use any bodily restraints. He only closes up the eye he has operated upon by a strip of soft salicylated silk isinglass plaster, and he leaves the other eye open so that the patient can see to walk about, to feed himself, and to make his own toilet at bedtime and when he gets up in the morning. The eye operated upon can be daily inspected through the diaphanous adhesive plaster. By the fifth day the covered wound has healed, and the strip of adhesive plaster removed. He claims for this treatment better results than he ever got in previous years, when he practised all the restraints in general use. His experience, which covers hundreds of cases, shows that eyes treated in lighted rooms escape much of the irritability which is found, when the bandage is removed, in the dark-room treatment. Since the operation without iridectomy has been reintroduced, Dr. Chisolm's extractions are by the new method. In the hospital 150 of these have been done with the most excellent results. Hernia of the iris very seldom occurs, and not more frequently than in the practice of the most skilful eye surgeons who still think the bed treatment and absolute quiet an essential item in the success of the operation. Dr. Chisolm has had 30 years' experience as an eye surgeon, and has performed upward of 1800 cataract extractions, a much larger experience than any other surgeon in the United States. For 25 years he treated his patients in dark rooms, under thick compresses. For the past 4 years he has practised just the opposite treatment, of closing only the eye operated upon, and using light rooms with no bed confinement, and without bodily restraints of any kind. His experience has proven to him that the new plan of treatment is by very far the better one. Hence he makes war against what he deems relics of a former bad surgery which should be abandoned, and should only be remembered for the needless annoyance which it inflicted upon over-docile patients. —*Weekly Med. Rev.*, June 14, 1890.

REPORT ON DISEASES OF THE EAR.

Green (J. O.) on Cases of Meningitis from Inflammation of the Tympanum.—All four cases reported by the author are demonstrations of the failure of the operation to avert the fatal result where the meninges have been already infected, however successful the operation may be in cleansing the original source of infection, and this brings up the question of the surgeon's duty in such cases. We find two varieties of meningitis from inflammation of the ear, one infection by absorption into the circulation, but the exact path by which the morbid material is carried from the ear to the meninges is not yet known; the other an extension of inflammation *ex contiguo* from the bone to the dura mater and thence to the other meninges. The first is infection from a distance, the other from direct contiguity of tissue. The former is a rapid process, and once established is necessarily fatal; the latter is a gradual process, in its incipiency localized and occasionally cured. It is impossible to distinguish between the two from any early symptoms, and it is equally impossible to say at what precise moment the meninges have become infected in either variety. The differential diagnosis between meningeal irritation and meningeal inflammation is, in the beginning, impossible. This being the case, the author is inclined to give the patient the benefit of evacuation of pus and cleansing of the bony cavities merely on the possibility that he is dealing with the second

variety, which has not yet fairly infected the membranes of the brain.

Years ago the author operated on a case which was in a state of apparently active meningitis and which recovered from the ear disease and also from the meningitis, but died some months after suddenly with symptoms of a ruptured brain abscess. It probably was a case of the second variety at the time of operation. Cases of meningeal irritation recover after the operation in a number of instances where the symptoms in the head were so exactly like the early symptoms of some cases of meningitis that they could not be distinguished from them. Of eighty cases of opening the mastoid for inflammation which the author has recently been tabulating from his notes, three, besides the four cases here reported, died, all from infection of the meninges before operation. In this series there are two cases of meningeal irritation, one of which made a perfect recovery in the ear and head, the other recovered from the head symptoms, but a cholesteatomatous mass developed in the mastoid some years after.

The full statistics of these cases are as follows: Cured, 62; not cured, 3; died, 7; unknown, 2; unfinished, 6; total, 80.—*Boston Med. and Surg. Jour.*, June 19, 1890.

Sainsbury and Battle on Cerebral Symptoms Accompanying Disease of the Middle Ear; Operation on the Ear; Complete Cessation of the Symptoms.—George P., aged thirty, laborer, formerly in the army, admitted into hospital with headache, vomiting, drowsiness, symptoms which had supervened on exposure to heat. Had previously suffered from similar symptoms during Egyptian campaign. No history of syphilis.

State on admission: Headache, *severe*, passing from occiput over vertex to forehead; pain at back of eyeballs; giddiness; sleeplessness. From a persistently drowsy state he could be roused to answer questions, and was quite clear in his answers, but they came with effort. Complaint of pain down spine to loins, and of pain on bending the back. On the lips some patches of herpes; slight cough, with moderate expectoration; slight dulness at bases of lungs posteriorly, especially on left side; temperature irregularly raised; pulse full, rather incompressible. Optic discs, tortuous vessels blurred margins.

Further condition: Intractableness of symptoms; no relief to head from increasing doses of potassium iodide. Both optic discs intensely inflamed; occasional eye symptoms, viz., unequal pupils, once or twice; double vision also once or twice; temperature curve pyrexial, very irregular. Cough continued; expectoration occasionally blood-stained. Subsequent discovery of deafness in one ear, and of disease of middle ear, viz., granulation polypus.

Operation: Removal of diseased bone from ear by Mr. Battle. Immediate relief of symptoms. Cessation of cough and of sanguineous expectoration. Inflammation of optic discs very soon began to mend; and all swelling had disappeared when the patient was discharged, seven weeks after the operation.—*Med. Press*, May 14, 1890.

Smith (A. H.) on a Case of "Ear Cough."—Mr. V., a robust man, about thirty-five years of age, called on me May 3d, with the history that he had had the influenza in January, and had not been free from cough since. The cough was very frequent, of a dry character, and resulted in expelling very small pellets of mucus. It was extremely troublesome at night, depriving him of rest, and each morning on arising there occurred a paroxysm so severe as to leave him completely exhausted. His appetite and digestion were normal.

Physical examination of the chest, and also of the abdomen, gave a purely negative result. Searching for a reflex source of the cough, I examined the oral and nasal cavities without result. The left ear also was found normal, but the speculum showed on the posterior wall of the right meatus a red, shining, dry patch of thickened membrane, evidently the result of a chronic inflammation. This was sensitive to pressure with the probe, but the patient was not aware of its existence.

Believing that this was the source of the cough, I applied as a test a solution of cocaine on a pledget of cotton, directing the patient to renew the application on going to bed, and again in the morning before rising. The result was a night of perfect comfort, and an absence of the usual morning paroxysm of cough. A few days of treatment with a weak solution of chromic acid, and afterward with nitrate of silver, effected a perfect cure without the use of internal medication.—*Va. Med. Mo.*, June, 1890

Bates (W. H.) Hearing Restored in a Deaf-Mute by Treatment.—Rose D., aged nineteen, had cerebro-spinal meningitis when three years old. Her hearing was suddenly lost at that time. She has attended school at the Deaf and Dumb Asylum, Fordham, until recently.

On February 11, 1890, I began treatment. She did not hear the ticking of the watch, loud conversation, or the sound of her own voice. The Eustachian tubes were not easily opened by Politzeration. Drum membranes transparent, slightly sunken. Tinnitus was present. The history of the patient, deafness following cerebro-spinal meningitis, would have indicated incurable internal ear deafness, and the negative appearance of the drum membranes would have supported this supposition. The tuning-fork, however, gave the well-known formula that we obtain in many uncomplicated cases of catarrhal inflammation of the middle ear, a condition that can often be benefited by treatment.

Treatment was pursued daily for a month by inflation and the application of nitrate of silver to the vault of the pharynx. Her family physician was giving her constitutional treatment.

March 11th.—Watch heard at twenty inches. Hears conversation at ten feet. Is learning to talk. Treatment now three times a week. Hearing steadily improved in both ears.

May 15th.—Watch heard at five feet. Conversation heard at twenty feet. Tinnitus much better. Her talking resembles that of a child just learning to speak.—*N. Y. Med. Jour.*, June 7, 1890.

Wright (A. H.) on Epithelioma of the Ear, Following Frost-Bite; Amputation of the Pinna.—W. W., æt. 55, male, farmer, a strong, well developed man, admitted into the wards of the hospital on June 18th, with the following history: His ears were both badly frozen twenty-eight years ago, and they remained somewhat thickened and swollen ever since. Eight years ago a little depression appeared at the upper and posterior portion of the tip of the right ear; this was of the color of a mole, but was rough like a wart; a scab would form and come off occasionally. The ear remained in this condition for four years, at the end of which time it looked like a small wart with little round "seeds" in it. Three years ago removal of the growth was advised, but it was allowed to remain until November, 1888, when the diseased portion of the pinna was cut out. The wound healed well. It began to re-appear in August, 1889, and three months after, discharge began to come away from it. A caustic paste was applied for four months, but the condition became worse under treatment. The disease having extended considerably, the patient decided to come to the hospital for operation.

The family history is good, no cancer among the patient's relatives.

On admission, the right pinna presented a peculiar appearance; it was purple in color, as if engorged with venous blood, the tissues were thickened very considerably, and felt like a piece of leather, when grasped between the finger and thumb. The whole pinna presented these unhealthy features, with the exception of the tragus and the lobule, which were perfectly normal in appearance. There was a notch in the posterior and upper portion of the pinna, the seat of the former operation. The tissues at the base of this notch were ulcerated, presenting a raw, uneven surface, and a portion of the helix both in front and behind the notch was in the same condition.

On the inner aspect of the pinna, just below the notch, was a small sloughing surface about the size of a five-cent piece. The thickening of the tissues was very much greater at the base of the notch than elsewhere in the pinna. There were no glandular indications detected. The left ear, which had also been frost-bitten, was somewhat thickened and dark in color, but there was no ulcerative process nor marked growth in it.

Amputation of the pinna was advocated, and was performed by Dr. Wright, on June 19th, in the following manner: A vertical incision was carried through healthy integument at the bottom of the concha, one-quarter inch behind the external auditory meatus; this was carried vertically upwards over the helix, and down on the inner aspect of the ear, close to the bottom of the sulcus, between the pinna and the scalp. The incision was then continued through the posterior portion of the lobule until the starting-point was again reached. The integument was now dissected up towards the meatus anteriorly, and towards the scalp posteriorly, and the cartilaginous portion of the pinna was then completely

cut through, and the amputation thus completed. The greater part of the lobule was left, and the tragus, these portions being quite unaffected by the disease. The flaps were now brought together accurately by interrupted suture and an antiseptic dressing applied. Bleeding was remarkably profuse during the operation; the cut vessels were, however, readily secured, and either twisted or ligated. The wound healed readily by first intention.—*Canadian Practitioner*, July 1, 1890.

REPORT ON CUTANEOUS DISEASES.

Berry (G. A.) on Vaccinia of the Eyelids.—I have not been able to find any reference, in the different text-books on diseases of the eye, to the accidental occurrence of vaccine pocks on the eyelids. I am inclined to think, however, that such an accident is by no means so rare as this would appear to indicate. Possibly a good many cases do not come under the notice of the ophthalmic surgeon at all, but are recognized and treated by the family doctor. I have seen in all five well-marked cases. Four of these occurred in women, one was a man of thirty. In all there was a distinct history of inoculation, or rather of the possibility of inoculation. A child had been vaccinated ten or fourteen days before the patient was seen. In all the pock occurred on the lower lid, but there were also to be found one or more ulcerated patches on the margin of the upper lid where it came into contact with the macerated surface of the primary vaccine ulcer. The swelling was always great, and involved not only the lids, but also the cheek. The base of the ulcer was decidedly harder than the surrounding swelling, but not so distinctly indurated as in the case of chancre of the lid, and the glands were not swollen. There was, comparatively speaking, very little pain; practically no spontaneous pain, and but little tenderness to touch. In no case was the eye affected. The affection never led to any alteration in the position of the lid, and even the cicatrix left was slight, barely perceptible, owing no doubt to the laxity of the skin in this situation.

The main interest in these cases consists in the possibility of the inoculation taking place at all, and in the differential diagnosis between vaccinia and a primary syphilitic sore. As to the manner of inoculation, in three of my five cases this could not be satisfactorily ascertained; in one there was little doubt that a direct transference of lymph took place owing to the child's arm being often in contact with its mother's face; in another the handkerchief used for wiping the vaccinated arm was admittedly used by the mother also.

Chancres of the lids, to judge from one's own experience, are of decidedly more frequent occurrence than vaccine ulcers. For the reasons above stated, this may, however, be only apparent. It is not unlikely that vaccine pocks in this situation have sometimes been mistaken for syphilitic sores. The latter is always a more distinctly clean-cut, eaten-out ulcer, which has taken a considerable time to develop from its first appearance as a pimple at the lid margin. The opposite lid margin is not ulcerated as a rule. The base of the ulcer is greatly indurated, and the preauricular, as well often as the submaxillary glands, are swollen. There is no history which can in any way connect the case with vaccination, and usually one which renders a syphilitic contagion possible. Lastly secondary symptoms appear in due course. —*Edinburgh Med. Jour.*, July, 1890.

Balzer on Vaccinia Complicated by Gangrene during the Early Stage of Syphilis.—It was observed in a woman, twenty-three years of age, who came to the hospital suffering from secondary syphilis and gonorrhœa. She was placed under energetic treatment, during which she was vaccinated. Only one inoculation "took," which, however, soon became black and extended until it involved an area the size of a silver dollar, limited by an inflammatory induration. Notwithstanding antiseptic local treatment with iodoform, salol, etc., it was only when large doses of potassium iodide (ninety grains in the twenty-four hours) were given that the eschar separated.—*Med. News*, June 7, 1890.

Rolleston on a Peculiar Desquamation in Typhoid Fever.—Dr. Rolleston relates a case of enteric fever which was attended by desquamation in large flakes in the commencement of the third week. The epidermis of the trunk and thighs came off in large flakes, while that of the hands and feet peeled in small bran-like scales. There was no history pointing to scarlet fever, and there was no evidence

of any dermatitis or erythema, which might account for the desquamation of the skin. The interest of the case centred in the diagnosis of enteric fever, which seemed certain, though shaken by evidence which at first sight suggested scarlatina. Clapham has recently seen a case of typhoid fever characterized by diffuse desquamation. The rash appeared late, and with it large roseolous patches came out over the trunk. In the third week desquamation of large areas of epidermis occurred. This was followed by a relapse lasting a fortnight, but the patient ultimately made a good recovery.—*Lancet*, Jan. 18, 1890.

Treatment of Tinea Tonsurans.—EDITOR MEDICAL ANALECTIC AND EPITOME.—From time to time I have seen certain forms of treatment recommended for *tinea tonsurans* in your valuable periodical. I wish to recommend to my professional brethren the following treatment which I have found most useful in ringworm of the scalp and body. Cut the hair short and wash the scalp well with tincture of green soap, and then apply the following solution with a camel's-hair brush: ℞ Hydrargyri chlorid. corrosiv. gr. ÿ, collodii ʒj, M. This treatment may be recommended for four reasons:

(1) The corrosive sublimate destroys the fungi.

(2) The ether of the collodion penetrates to the root of the hair, conveying the corrosive sublimate to the seat of the disease.

(3) The film formed by the collodion shuts off the supply of oxygen to the fungi and thus helps destroy them.

(4) And the film also prevents the hairs from flying about through the atmosphere and carrying the germs to other persons.

I have treated a large number of cases with this solution with most excellent results. Yours respectfully,

JAMES Y. SIMPSON,
Independence, Mo.

Illingworth (C. R.) on the Treatment of Ringworm.—If a solution of the biniodide of mercury in the iodide of sodium, prepared by adding half a drachm of the former to half an ounce of a one in four solution of the latter, and then diluting with four parts of water, be applied once, with a camel's-hair pencil, it will cure the disease.

Your correspondent has used biniodide ointment, but the greasy vehicle prevents the requisite penetration, whilst there is no more penetrant salt than the sodic iodide solvent.—*Med. Press*, July 9, 1890.

Lupus and Peru Balsam.—Dr. W. Beck presented a patient before the Nürnburg Medical Society last week who had lupus over a great part of the under extremities. The patient had been to Vienna in 1877, where he attended hospital for several years, during which time he was vesicated, cauterized, and scraped with a dermic gouge, but with little benefit. In November, 1889, the patient came to him, whereupon he removed all the new growth with the "dermic shovel" and "Paquelin," and dressed the fresh wound with Peru balsam, which he applied on boracic lint, with antiseptic bandages!! It was dressed every second day, later every fourth day. He had now left the hospital perfectly cured. Tubercular bacilli could not be found in any of the overgrowth removed from the wounds, nor could they be found in the sputa.—*Med. Press*, June 25, 1890.

Staniforth on Varicella Gangrenosa.—The patient was a boy aged seventeen months. The vesicular eruption was preceded by about twelve hours by a scarlatina-like rash, and the patient's mother stated that the whole family had suffered from "scarlet-fever and measles" four months previously, which Mr. Staniforth thought indicated a family tendency to a scarlet rash as a preliminary to an exanthematous eruption. On the sixth day of the disease most of the vesicles had dried up into hard black scabs surrounded by erysipelatous-looking areas, varying in size from a sixpence to a florin. By the tenth day the whole of the vesicles except those on the head and face had become converted into deep circular ulcers, which had a clean, punched-out appearance, and extended down to and exposed the fascia. In the centre of several were ashen-gray sloughs. Three weeks and a half after the commencement of the attack the ulcers began to heal. During the attack the child was very restless, the pulse rapid and feeble, and the temperature at first high, but subsequently above 100° F. There was no family history of syphilis or tuberculosis. The patient had had vaccinia and measles, and had been suckled at the breast. Another member of the family began with varicella exactly fifteen days after the appearance of the rash in the former case, but recovered in ten days without any complications.—*Lancet*, Jan. 4, 1890.

Andrew on Hemorrhagic Varicella.—One case was attended by profuse hemorrhage from the alimentary canal (hematemesis and melæna) and by ecchymoses in the skin. In the other, an instance of varicella grangrenosa, described by Mr. Hutchinson, ulceration took place in the varicella, with an offensive purulent discharge and general symptoms of septicæmia. The two cases occurred in the course of the same epidemic of varicella in a large school.—*Lancet*, Jan. 18, 1890.

Fox (C.) on the Urticaria of Infancy.—The author holds that the affection is not to be regarded as a concurrence of two diseases, an inflammatory papular one and an urticaria, nor as essentially a prurigo with some secondary wheals, but that it was an urticaria, and the urticaria of infancy and early childhood. The special feature of this urticaria was that, on account of the ready response to any irritation on the part of an infant's skin, an inflammatory papule was developed in each wheal, and was left on the subsidence of the wheal. Though this complicating inflammatory lesion was usually papular, it was sometimes vesicular, pustular, or bullous, and occasionally these several phases could be seen in the course of a single case. The affection had no direct relation with vaccinia, varicella, measles, or scarlatina.—*Lancet*, June 7, 1890.

Hills (J. D.) on Acne Indurata.—If taken early, the treatment of acne vulgaris is unattended with any difficulty. It is quite a different matter when the case is neglected, as in this instance, or improperly treated.

Miss E. was ordered a bland unstimulating diet, and twice a week the following pills at bedtime, followed by a wineglassful of Hunyadi Janos water in the morning:

℞. Pil. hydrarg. . . . . gr. iij.
Pil. rhei. co. . . . . gr. vij.

Ft. pil., ij. Also:

℞. Acid. nitro. hydroch. dil., . ʒ ij.
Tinct. cinch. co. . . . . ʒ j.
Infus. cascarillæ . . . . . ad. ℥ viij.
Ft. mist. sp. coch. amp. ter die.

Morning and evening the patient was directed to bathe the face with warm water as hot as could be borne, and the following ointment afterwards applied:

℞. Iodid. sulphur. . . . . gr. x.
Lanolin . . . . . ʒ j.
Ft. unguent.

Each pustule was touched with the acid nitrate of mercury twice a week.

This treatment was steadily persevered in, and on the 23d of December, 1889—about three months,—the nodules and all signs of the disease had entirely disappeared.

I would point out the great value of iodide of sulphur as a local application. The strength should never exceed ten grains to the ounce in the first instance, and perseverance in its use will certainly be rewarded by the ultimate cure of one's patient.—*Med Press*, June 11, 1890.

Williamson (C. F.) on Alopecia Areata Following Influenza.—A widow, aged thirty-five, had an attack of influenza during the last week of January this year. All her children (seven in number) were affected at the same time. She complained of great pain over both the eyes and at the back of the head, the former pain being most acute over the course of the supra-orbital nerves, and the latter over that of the occipital. At the end of a week she was able to resume her household duties, although the headache continued. In the middle of March she had another attack of influenza, complaining of the same kind of headache. This attack lasted only a week. I lost sight of her then till the beginning of May, when she came suffering from headache and gradual loss of hair. The headache had continued from the first attack in the same situations, and been most acute, but the loss of hair had only commenced after the last attack. On examination, there was baldness in patches over the courses of the supra-orbital and occipital nerves, and the skin was very tender to the touch. Each patch exhibited the usual characteristic signs of alopecia areata. There were no gray hairs, nor had the hair turned gray before it perished. She had no loss of hair on any other part of the body, nor were the children affected in a similar way. For the headache an ounce of the following mixture was ordered to be taken every four hours: Chloride of ammonium, three drachms; water to six ounces. For external application: Tincture of cantharides, two drachms; strong solution of ammonium, four drachms; water to six ounces; to be rubbed in every night and morning. In a few days she had entirely lost all pain in the head, and now, after the lapse of two weeks, the hair has begun to grow.—*Lancet*, June 7, 1890.

REPORT ON SURGERY.

Powers (C. A.) on Conical Stump after Amputation in Children, with Especial Reference to its Physiological Causes and Prognosis.—The author concludes that:

1. Amputation through the arm or leg in children may be followed by a conical condition of the stump, and this sequel is a probability rather than an improbability.

2. This conicity may be physiological, and independent of inflammation or retraction in the soft parts or of osteophytic deposit at the end of the bone.

3. The younger the child and the nearer the seat of the amputation to the upper epiphysis of the limb, the greater the probability of early conicity. These factors should be considered when making prognosis.

4. The weight of extant authority favors flaps of excessive length, but this measure may not prevent development of the conical condition.

5. When the conical condition is present, the only suitable treatment consists in the resection of a sufficient portion of bone.

6. Successive re-amputations may be required.

7. The above considerations may apply, but with very much less of force, to amputations through the forearm or thigh.

[The recorded cases of conical stump in children are few in number and it would seem of value to gather all possible additional information.

I would, accordingly, request physicians who have observed amputations above the wrist or ankle, in patients under eighteen years of age, to kindly send me (35 West Thirty-Fifth Street) a brief note, stating the seat of the amputation and the ultimate condition of the stump.]—*Med. Record*, June 7, 1890.

Collier (M.) on Spasmodic Torticollis Treatment by Nerve Ligature; Complete and Permanent Recovery.—A fairly healthy-looking girl aged twenty-one, was brought to me in January, 1889. She was a well-developed, intelligent girl, with a family and personal history remarkably free from any neurotic or other complaints. Her affection dated from 1883. It had gradually supervened, and culminated in a most distressing state of things, the head being so extremely rotated as to bring the left ear with sudden jerks into a line with the sternum. This took place every few seconds, not altogether ceasing, although less violent during sleep. With regard to treatment, she had been dosed with drugs innumerable, galvanized, blistered, her tonsils removed, and the galvano-cautery applied to the back of the throat, without beneficial results. I sent the case to St. Thomas' Home, and there, with Drs. Edmunds and Sutton's valuable assistance, had little difficulty in finding the spinal accessory nerve emerging from the outer border of the sterno-mastoid muscle. Taking the nerve as a guide, I tunnelled through the muscle for some distance, using a moderate amount of traction on the nerve, but avoiding injury as far as possible to the muscle. This done I placed a loop of silver wire round the nerve as high as I could reach, just twisting the ends to ensure slight compression. The wound was treated in the usual way, the ends of the loop protruding. On recovering from the chloroform the spasms had entirely ceased. The wound subsequently healed by first intention, without pain or discomfort in any way. After a fortnight the patient returned to her home in Kent. At the end of three months she visited me, still without the smallest return of the spasms, and much improved in health. Nothing seemed amiss with the sterno-mastoid or trapezius; she could rotate her head, and retain it in any position. I cut off the ends of the loop as close as possible, so as to allow the skin to grow over them. I have not seen the patient since, but learn from time to time from Dr. Sutton that she remains perfectly free from a return of her troubles. *Lancet*, June 21, 1890.

Laparotomy for Tuberculous Peritoneum.—At the Société de Chirurgie M. Terrillon presented a little girl on whom he operated a few months previously. When he first saw the child, her general condition was very bad, the cachexia was profound, and the abdomen hard and swollen, although no ascites was present. When he opened the peritoneum he found it covered with tubercles, and the intestines adherent by means of false membranes. After having destroyed the adherences and cleaned out the cavity M. Terrillon closed the wound. The child made a rapid recovery, and has gained since the operation 8 lbs. in weight. M. Richelot said he obtained similar results in two cases, and in each of them ascites to a considerable extent was present. M. Terrier said that all

the granulations met with in the peritonitis were not necessarily tuberculous. By inoculation alone could their baciliary origin be proved. He thought also that one should not be too sanguine of the sometimes surprising results which immediately followed surgical intervention. The pulmonary lesions persist, and the amelioration is only temporary.—*Med. Press*, July 9, 1890.

Currier (C. G.) on the Sterilization of Water.—Unless extraordinarily resistant, water becomes sterilized if it be at or near the boiling temperature for fifteen minutes. If the same degree of heat be maintained for five minutes, all harmful micro-organisms will have been destroyed. Still less time serves to destroy the disease-producing varieties which are recognized as liable to occur in water. Thus merely raising to the boiling-point a clear water containing the micro-organisms of malarial disorders, typhoid, cholera, diphtheria, or of suppurative processes, and allowing it to gradually cool, insures the destruction of these germs. They are also destroyed by keeping the water for from a quarter of an hour to half an hour at a temperature of 70° C.

Occasionally, however, very resistant but harmless bacteria may get into the water. The brief heating renders them safe for drinking purposes; but when it is desired to destroy every micro-organism that may be present in a contaminated water, it should be heated for one hour and allowed to cool slowly. Then it may be used for cleansing wounds or for alkaloidal solution which will keep indefinitely if no germs be introduced after the solution has been heated.—*Med. Record*, June 14, 1890.

White (J. W.) on a Method of Applying Antisepsis in the Treatment of Recent Anterior Urethritis.—The following are the conclusions of the author, some of which are closely parallel with those of M. Dreyfous:

1. The microscopical and experimental evidence in favor of the bacterial orgin of gonorrhœa is confirmed by clinical and therapeutical experience.

2. The results of antiseptic treatment have not been so uniformly successful as would be expected, on account of: (*a*) the anatomical and physiological peculiarities of the male urethra; (*b*) the difficulty of applying sufficiently energetic local antisepsis; (*c*) the necessarily intermittent character of such applications; and (*d*) the failure to combine with the topical treatment appropriate internal medication.

3. No one antiseptic agent can be depended upon, in the strength at which it can be borne by the inflamed urethral mucous membrane, completely to sterilize the discharges and the suppurating surfaces. A judicious combination of several antiseptics, if not essential to success, is at least of considerable value.

4. The internal administration of salol in conjunction with copaiba and cubebs renders the urine aseptic and probably antiseptic, so that it acts as an exceptionally thorough and efficient antiseptic injection, shortening the duration of the disease and diminishing the frequency and severity of the complications.

5. The production of urinary asepsis by internal medication is of considerable value not only in the inflammatory affections of the genito-urinary tract, but in the preparation of the patient for operation upon those organs and in the after-treatment.—*Med. News*, June 14, 1890.

Brown (F. T.) on Diphtheria of the Meatus Urinarius.—Young man, nineteen; healthy. Dirty household cotton used by the patient to cover the gland. Infection rapidly developed within thirty-six hours. When next seen, presented a raised-up, waxy-like formation over the meatus, which microscopically showed cocci, diplococci, streptococci, besides three varieties of bacilli. For the next three days, newly formed caps were removed with increasing difficulty. Finally, necrotic action resulted in the loss of the tip of the glans and contraction of the meatus. Constitutional symptoms slight, but pretty clearly brought out by the advent, short continuance, total disappearance of albuminuria, with certain renal elements shown microscopically. Recovery complete, without extension of diphtheritic process along the urinary tract.

Dr. Taylor has seen cases following circumcision, particularly in those who lived in squalor and poverty. The glans penis was attacked with redness of an exudate character, and was promptly covered over with this dirty-colored membrane, which in its first stages had the appearance of tallow. As that increased, it dried into this tough, brownish-white membrane. He has seen the same diphtheritic condition on he healing surface of chancres.—*Boston Med. and Surg. Jour.*, July 10, 1890.

THE MEDICAL ANALECTIC AND EPITOME.

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE.

EDITED BY R. W. AMIDON, M.D.

VOL. VII., No. 8. August, 1890. WHOLE No. 160.

SOME RECENT FRENCH CONTRIBUTIONS TO SURGERY AND MEDICINE.

Lannelongue on Craniectomy in Microcephaly.—The patient was a girl, of four years, having cranial deformities and signs of microcephaly of a grave nature. The child was born of healthy parents, who had five other children, all healthy. She was always backward, and had not walked, up to the age of three. She spoke only a few syllables, drooled, was small and puny, and appeared like an undeveloped child of two. She was thin, 30½ inches high, with a chest girth at the nipples of 17¾. Put upon her feet she fell at once, and all movements she attempted were disorderly. She uttered almost continuously inarticulate cries, and seemed entirely indifferent to playthings or caresses.

The head was small, narrow, and flattened transversely, prominent on the vertex, and of the scaphoid type. The face was prognathous, the forehead retreating and narrow; in short, the patient presented all the signs of microcephaly and idiocy.

The author removed, May 9, 1890, a piece 3¼ inches long by ¼ inch wide from the left parietal bone, extending along the sagittal suture from the frontal to the occipital bone. The dura mater was not opened, and the superficial wound healed by first intention.

A notable amelioration followed the operation. The child became calm, and the phenomena of cerebral excitation disappeared. There was noted a progressive and rapid development of intelligence, the child playing, laughing, and seeming to understand. She even attempted to speak some words, and held herself up and commenced to walk. The drooling stopped and she ate at the table. The local process was perfect, the cicatrix being mobile and non adherent.—*La Tribune Méd.*, July 10, 1890.

Parinaud on Delirium after Cataract Operation. — The occurrence of delirium after operation for cataract has long been noticed, but hitherto not fully understood. The delirium generally takes the form of maniacal excitement.

Many authorities attribute it either to atropine or alcohol.

The author attributes the delirium to the too great preoccupation of the patient, produced by bandaging both eyes.—*La Presse Méd. Belge.*, May 25, 1890.

Marandon de Montyel on a Revolt of Lunatics.—On May 13, 1890, six insane, in the ward for agitated at Ville-Evrard, after consulting together, fell upon an attendant charged with giving them a bath. Seven other attendants, running to the other's assistance, were received by kicks and blows, and were practically repulsed.

At the breakfast-hour the director, the physician-in-chief, and his assistant on their appearance were received with a volley of dishes, and were assaulted by the patients with their fists.

The infuriated patients could not be quieted, and had to be sequestered. The rest of the patients remained tranquil.—*La Tribune Méd.*, July 24, 1890.

Nægely on the Treatment of Trigeminal Neuralgias. — The author found he could cut short attacks of whooping-cough by sharply lifting the lower jaw forward and upward. He also found that he could quiet persistent trifacial neuralgias by elevating the hyoid

bone and larynx for from seventy to eighty seconds. With the patient facing the operator, the hyoid bone, etc., is lifted by the thumbs, the index fingers resting in the ears, and the other fingers on the back of the neck; the effect is instantaneous. He has thus relieved hemicrania, orbital neuralgia, nausea of nervous origin, etc.

In more than fifty cases he reports only success.—*L'Union Méd.*, July 12, 1890.

Lemière (G.) on Aseptic Suppuration in the Rabbit.—The method of experimentation employed by the author was to introduce under the skin of various animals small amounts of aseptic metallic mercury. In most cases local suppuration followed, but the pus was free from germs, as proven by the microscope and culture experiments.

The author concludes that mercury possesses pyogenic properties, and produces, when introduced into healthy subcutaneous tissue, aseptic suppuration. This suppuration seems due to a chemical action provoked by a mercurial compound, produced by the reaction of organic liquids upon the mercury.

This action was noticed in dogs, cats, rabbits, guinea-pigs, and rats, differing according to the inflammatory reaction of the animal; dogs and cats responding sooner than other animals. In the former animals necrosis of the skin often ensued, and among the latter complete recovery of the animals, with absorption of the abscess contents.

These suppurations produced no pyæmia or generalization, nor visceral metastases, although there were some metastases in the cellular tissue through the lymphatic channels.—*Jour. des Sci. Méd. de Lille*, June 13, 1890.

Francotte on Paternal Heredity of Infectious Microbic Diseases.—The author has studied the action of many micro-organisms, whether pathogenic or saprophytes, upon spermatozoa, and invariably finds that whenever a microbe penetrates a spermatozoön it renders it unable to fecundate an ovule, and, in short, kills it. This goes to show that microbic diseases are not directly transmissible from father to offspring by means of the sperm. According to this theory, syphilis and tubercle cannot be directly transmitted from father to offspring, but only the morbid predisposition to the disease.—*La Presse Méd. Belge.*, May 18, 1890.

Marfan (A. B.) on Chancre of the Septum Nasi.—A boy of seventeen had sexual intercourse with the same woman on three different occasions: July 14th, August 20th, and September 20th. Towards the end of September he noticed a tumefaction in the submaxillary and parotid region of the right side. This swelling grew larger for eight days and then remained stationary. Oct. 15th a syphilitic roseola broke out and he applied for treatment. On close examination the primary lesion was found to be a small hard chancre on the right side of the nasal septum not quite half an inch from its lower border. The virus had probably been carried to the nose by the finger of the patient.—*Annales de Dermat. et de Syph.*, June 25, 1890.

Robinson on a Mercurial Eruption Consecutive to the Internal Use of Calomel.—A man of forty-five had gonorrhœal rheumatism in 1886, for which he was ordered mercurial inunctions, and internally very free balsamic medication. Severe mercurialization followed: swollen, painful tongue, loosened teeth, salivation, fetid breath, papular and pustular eruption accompanied by an atrocious itching, and followed by a furfuraceous desquamation. Temperature, 101° to 102° F.; delirium, loss of appetite, tremor, albuminuria, etc. All these symptoms disappeared under appropriate treatment.

The same patient consulted the author in 1888 for an alcoholic gastritis and hypertrophied liver, to relieve which condition the author ordered gr. iiss. of calomel every three hours until four doses were taken. Some hours after taking the first powder he had a chill lasting half an hour, followed by a fever lasting the whole night. In the morning he noticed an eruption consisting of large red blotches, and soon there followed symptoms of mercurialism similar to those occurring before, only the itching eruption was miliary and scarlatiniform. The red patches and vesicles both became later pustular.—*Ann. de Thérap. Méd.-Chir.*, May, 1890.

Gouguenheim on Salol in Sore-Throat.—The author thinks salol efficacious in all kinds of sore-throat. It quickly calms the pain and dysphagia, and by so doing cuts short the course of a quinsy and lowers the temperature. To attain such results it should be given in at least drachm doses.—*La France Méd.*, June 6, 1890.

REPORT ON OBSTETRICS AND DISEASES OF CHILDREN.

BY ELIZABETH STOW BROWN, M.D.

McNaughton (George) on Accidental Separation of the Symphysis Pubis during Labor.—This accident has been more fully treated by European authors than by those of America. Ahlfeld believes that injuries to the bony pelvis are not infrequent, and that the physician should always look for them after a particularly hard or tedious labor. This accident doubtless occurs more frequently than has been reported. Some physicians fail to publish their cases, either from indifference or reserve. The author has so far been unable to find an original case reported from America.

The patient when first seen by the physician was three months pregnant, and exhibited an extreme degree of vaginismus, so severe as to necessitate ether for a thorough examination. Nothing unusual occurred till labor began at term. For about thirty hours nature was allowed to take her course. The patient was in excellent condition, os dilated, pains regular and vigorous but ineffectual. The head presented L. O. A., but was scarcely engaged at the brim. Simpson's long double-curved forceps were applied within the uterus, the handles pressed well back on the perineum. Considerable traction was made without moving the head a particle. The assistant then took the forceps, the author making pressure over the fundus. At the second attempt he thought he had started the head; at his third, both physicians were sure something had been started, for they were conscious of a distinct shock, and both thought that the forceps had slipped. On investigation such was found not to be the case, but the head had come down a little. Traction was again made, and a second sensation like the first was experienced.

It was impossible to say whether or not an audible crack occurred. It was rather the feeling of something unusual through the sense of touch. The child was quickly delivered, and its arrival was followed by a tremendous gush of blood, which did not seem to come from the usual source. On examination, the finger passed through a slit in the anterior vaginal walls, to the right of the urethra (as afterward ascertained) up to the separated pubic arch The points of bone were separated about one inch, and felt like bone denuded of its periosteum.

A catheter was introduced, the urethra put in its normal position, held there, and the vaginal rent stitched together. No drainage-tube was introduced. A tight bandage was placed around the hips, the knees and feet were tied together, and an opiate was administered for the relief o. pain, which was excruciating in the back and region of the symphysis pubis.

A general peritonitis developed, which continued to grow worse until death on the ninth day after delivery.

The chief means of treatment is in the application of a pelvic girdle or bandage. The upper part of the binder should come below the spine and crest of the ilium, since otherwise the posterior synchondroses will be disturbed; if the patient cannot stand the binder, she may be placed on her side. At the time that this case was under treatment the propriety was considered of suturing the points of bone, as is done after fracture of the patella.

Incomplete cures and fatal results occur even when the diagnosis is promptly made and the proper treatment applied.—*Brooklyn Med. Jour.*, April, 1890.

Whittle (Glynn) on Fifty Cases of Operative Midwifery, with Special Reference to Hemorrhage and Perineal Support.—From December, 1882, to April, 1889, the author's midwifery experiences were drawn from three sources: First, private practice; second, the outdoor department of the Ladies' Charity; third, the in-door department or Lying-in Hospital. The aggregate number of cases within these dates amounted to more than one thousand labors. As there were fifty operations—being the series which forms the subject of this paper—it follows that the proportion of cases in which operative interference was indicated was less than 5 per cent. Out of twenty-four cases of obstruction, from rigidity or contracted pelvis the children were saved in nineteen, and in no instance was perforation necessary. In three cases of arm-presentation, the death of the fœtus had preceded labor. Out of five cases of hemorrhage, the infants were saved in three. In the remaining eighteen cases, where the chief symptom was exhaustion, protracted labor, or prolapsus

funis, the children were saved. No death occurred among the mothers. Three of the cases of hemorrhage were accidental, and two the result of placenta prævia.—*Liverpool Med.-Chir. Jour.*, Jan., 1890.

Ayers (Edward A.) on Studies in the Decidua and Retained Membranes of the Ovum.—In the author's investigations with the microscope of retained membranes, he has noted some of the changes leading to death of the ovum, its retention, and consequent alterations.

The main points presented are: First, transformation of the epithelia in the utricular glands in some portions of the decidua into decidual tissue; second, an inflammatory process in the non-vascular amnion, which may be called amnionitis; and third, decidual hyperplasia.

The article is illustrated with several excellent drawings.

Studies are presented of the retained decidua, showing the transformation of epithelia in the utricular glands into decidual tissue; of fleshy mole, decidual hyperplasia, and amnionitis; and of subacute amnionitis in the case of placental tissues or residues that had remained in utero six weeks after a two months' abortion.—*N. Y. Med. Record*, April 12, 1890.

Wetherill (Horace S.) on a Triplet Delivery.—The patient had previously had three children with an interval of about two years between each birth. She was a small woman, weight ninety pounds. Her children were pale and rickety in early infancy, two of them having had spinal curvature and one knock-knee. The patient when taken in labor presented a very large abdomen, which at once suggested a multiple product of conception. Examination showed a thigh presenting, which by careful coaxing was extended, together with its fellow, and a rapid delivery accomplished without incident. The child was very small, not more than three pounds, but breathed well and was vigorous. A head was now found presenting, and while it was also small, it was making little progress, because there was no force in the frequent and exhausting pains. Forceps were applied, after some time had elapsed, and a rapid delivery was made. This child was larger than the first (weight nearly four pounds) and cried lustily.

While the cord was being tied and the child warmly wrapped in cotton, the uterus emptied itself at an expulsive effort, throwing out the triple placentæ, with the third child still completely enveloped in the membranes, which were very heavy, but from which the "waters" had escaped. This child kicked vigorously at once, and although very small indeed (about two pounds), cried as soon as it was exposed to the air by the tearing open of the sac. This child died in about thirty hours after birth.

The children (all boys) were apparently premature, and it seemed likely that the calculation of the mother was correct, and that birth had taken place at about the seventh month. In spite of care the children all died, one in thirty hours, the others in seventeen and twenty-one days respectively.

The placentæ were quite distinct, one loosely attached by membranes only, the others by marginal contact; the cords were centrally attached. The placentæ were full-sized for this period of gestation, and indicated that there were three distinct ova.—*Univ. Med. Mag.*, June, 1890.

Chapin (Henry D.) on Treatment of Diarrhœa in Early Life.—As the high mortality in cities is largely among artificially fed infants, the dietetic treatment assumes the first importance. All the recent advances in infant feeding have come from a close study and imitation of nature. As soon as bacteriology showed that human milk, as it comes from the breast, is absolutely sterile, and that cows' milk, kept from twelve to twenty-four hours, is full of bacteria, it was understood why the latter so often disagrees with the infant. The author dwells upon the importance of sterilization, but raises the question of the secondary effects of prolonged heat upon the ingredients of milk. Wishing to study this question, the writer instituted a number of experiments, carefully comparing the character of the curds formed in sterilized and plain milk upon the addition of various reagents. It was seen, from these experiments, that the prolonged heat necessary for sterilization has a tendency to make the caseine coagulate in smaller clots, but that there is still a very appreciable difference in the clot of cows' and human milk. The effect of sterilization upon the fat appears to be to collect it in rather larger globules. It is often noticed in nursing-bottles as flakes. Before administering the milk it should be warmed and thoroughly shaken, in order to split up the fat as much as possible. Experiment also showed that sterili-

zation partially or completely coagulates the albumen.

While sterilization is a great step in advance, it has by no means solved the question of infant feeding; there is a portion of indigestible caseine still to be dealt with. In cases of diarrhœa the attenuation of this caseine by barley or wheat flour, clinically, will often give good results. It is desirable to change as much of the starch into dextrin as possible before using these flours as attenuants. This may be accomplished by prolonged boiling in a tight bag. When the flour has been subjected to heat for a week, and a thin gruel made, and used to properly dilute the cow's milk, according to the age of the infant, an improvement in the character of the stools will often be noted. When vomiting is present, the use of lime-water in large amount, as a diluent, is beneficial. In many such cases there was used sterilized milk, thin gruel, and lime-water, one third each, with a little sugar of milk and cream, and with good results. Salt was always added to the bottle. In cases where the irritable intestinal tract will not tolerate milk, it is stopped for twenty-four or forty-eight hours. The nourishment then supplied was pressed beef-blood, with all traces of fat carefully removed, and diluted about five times with water, and the white of a fresh egg, stirred in a cup of water, or cold barley-water. The importance of administering plenty of fluid in these cases is emphasized by the rapid shrinking of tissue in infantile diarrhœa. The free use of water, both internally and externally, will do much to ward off the summer diarrhœa of infancy. Stimulation in the form of whiskey, according to the needs of the case, is recognized by every one as a valuable therapeutic agent.

The author's experience with stomach-washing, which he has given a thorough trial, has led him to the conclusion that while very serviceable in a restricted number of cases, it is by no means of such wide-reaching value or efficacy as would appear from the published results. In cases of acute indigestion and diarrhœa, good results were obtained from stomach-washing; but in bottle-fed babies, when long-continued malassimilation and atrophy were present, it failed as signally as most agents. In the great majority of cases those natural emunctories, the intestinal glands, if mildly stimulated at the beginning of the attack, will accomplish all the washing-out that is necessary. Hence the well-known efficacy of small doses of calomel, or castor-oil, given at the starting of diarrhœa. When the intestine has thus been emptied of offending masses, frequently all that is necessary is a most careful regulation of diet to prevent a continuance of the indigestion and diarrhœa.

In summing up, the following plan of treatment has commended itself to the author's judgment and experience: Careful sterilization of the milk, with proper dilution and attenuation. If, in spite of this, the milk will not digest, but continues to irritate, it is entirely stopped for a season, and beef-blood or egg-water substituted. Stomach-washing is very rarely employed, but the gastro-intestinal tract cleared of indigestible masses at the beginning by small doses of calomel or other unirritating laxative. Occasionally the lower portion of the bowel is irrigated with bismuth and starch-water. The principal internal medication consists in the administration of large and frequent doses of bismuth, to which pepsin or other agents to aid digestion may be added. Stimulation by alcohol. In cases that tend to become chronic, in spite of properly regulated diet, the cautious administration of small doses of opium. In all cases a careful restriction of diet, but a free allowance of water. —*N. Y. Med. Rec.*, June 21, 1890.

[This able article should be consulted in full by readers of the ANALECTIC. No abstract can do justice to its practical value.—E. S. B.]

Rachford (B. K.) on Some Points in the Dietetic Management of Summer Complaint.—The chief, if not the only, direct causes of summer complaint are abnormal intestinal fermentations, and these fermentations are chiefly of two kinds acid and putrid, the former occurring in carbohydrates, the latter in albuminoids.

The first great class of summer diarrhœa is caused by the formation in the intestinal canal of ptomaines from the fermentation of albuminous material. Constitutional symptoms are always present. The second class of cases is important rather in its numbers than in the severity of the types The cause in this class is the presence in the intestinal canal of local chemical or mechanical irritants. These irritants are produced, as a rule, by the fermentation of carbohydrates.

From these considerations the author formulates the following rules:

1st. Avoid albuminous food (*a*) when marked constitutional symptoms are present; (*b*) when in doubt as to the character of the fermentation causing the disease; (*c*) when the stools are putrid; (*d*) when stools contain mucus and blood; (*e*) when the nausea is constant, and not relieved by vomiting.

2d. Avoid carbohydrates as a food (*a*) when there are no marked constitutional symptoms present and the stools are continuously acid; (*b*) when there is much flatus, pain, or urticaria.

3d. When the albumens are to be avoided the carbohydrates are, as a rule, indicated; and when the carbohydrates are to be avoided, the albumens are, as a rule, indicated.

4th. Give foods such as cream, beef, beef broths, and whiskey (*a*) when the foods prescribed according to the above rules disagree; (*b*) during the first twenty-four hours in severe acute cases; (*c*) when in doubt as to the character of the food indicated.

It is not claimed that these rules are infallible, but that they are founded on sound principles; and that, in the present state of our knowledge, they furnish our most rational and reliable guides in the selection of a diet in summer complaint.—*Arch. of Pediatrics*, June, 1890.

Sachs and Peterson on a Study of Cerebral Palsies of Early Life, Based upon an Analysis of One Hundred and Forty Cases.—The authors present the following conclusions as the result of their conjoined clinical and pathological studies.

The form of paralysis is not the most important factor in diagnosis.

Acquired cases of hemiplegia and diplegia, but particularly the former, are apt to be due to the same causes that prevail in adult apoplexies; namely, hemorrhage, thrombosis, or embolism. Meningeal and cortical lesions are more frequent. Absence of convulsions at onset probably points to an intra-cerebral lesion. Occurrence of convulsions at onset points generally to cortical lesions or to embolism anywhere in the brain. In a few cases affections of gray matter lower down in the central nervous system may also be attended by convulsions.

Frequently repeated convulsions after onset point with great certainty to cortical lesion.

Cases coming on after acute infectious diseases have been proved to be due to vascular derangement, particularly to hemorrhage and embolism, but some cases may be due to a polioencephalitis corticalis; the onset with very high fever and convulsions makes the latter more probable.

Traumatism is an important factor in the causation of meningeal hemorrhage during early life and particularly during the act of labor.

Congenital cases of diplegia and hemiplegia may be due to early meningeal hemorrhage and possibly to an early encephalitis.

In acquired and congenital cases of hemiplegia and diplegia, we may have either a condition of porencephalus or simple arrest of development. If acquired, there would seem to be the history of slow development of the symptoms without predisposing cause. If congenital, there may be a history of traumatism to mother.

In later life hemiplegia or diplegia associated with large amount of mental impairment and with contractures points to general atrophy, sclerosis with secondary degenerations, or to a condition of porencephalus, the origin of which it is often difficult to determine.

In regard to treatment, the authors wish, so far as prophylactic measures are concerned, to repeat their warning to the obstetrician. Hasten protracted labor, for the skilful use of forceps and careful manipulation are less apt to do injury than the prolonged compression of skull and brain in the pelvic canal. In the acute cases the same principles which obtain in the treatment of adult cases should be applied.

Medical advice is generally sought for the relief of the secondary conditions—epilepsy, idiocy, and contractures.

In only two cases that the writers have seen of infantile palsies can they conscientiously state that there has been complete recovery.—*Jour. of Ment. and Nerv. Dis.*, May, 1890.

Finlayson (James) on Obscure Febrile Attacks in the Course of Chorea Referable to Endocarditis.—About twenty years ago the author, while studying the diagnostic significance of pyrexia appearing without any obvious explanation, as an important indication of latent tubercular disease, remarked the

occasional occurrence of short febrile attacks in the course of chorea. Since then he has repeatedly observed and watched for such complications in ordinary cases of chorea; but he remained for a long time without any theory of their causation. Finally a case occurred in the Glasgow Western Infirmary, which suggested endocarditis as an explanation. The child had been admitted as a case of chorea, of the left arm and leg chiefly, of some weeks' duration. She had a systolic murmur, heard best at the apex, but there was no history of rheumatism in the child. Under appropriate treatment the chorea was improving, when, three weeks after admission, the temperature rose from 98.6° F. in the morning to 100° F. at night; next day it remained about 100° F., but on the following day it rose to 103° F. at night, and remained high the next three days, in two days more declining to normal—that is to say, for five or six days there was moderately high fever, without any obvious cause in particular. Two months later the temperature rose again, and in this attack the idea of endocarditis was forced on the attention, not only by the quick pulse, but by the rapid respiration, without pulmonary complications. For five days the pulse, temperature, and respiration ran very high, and then the child died. Physicians who examined the heart during this attack were disagreed in regard to its condition. On autopsy it was found that the pericardium contained a small quantity of turbid fluid, and that there was a very slight fibrinous exudation on the surface of the left auricle. The left ventricle was somewhat enlarged and dilated. The auricular margin of the mitral curtain was lined with a scanty deposit of recent warty vegetations. The same condition, but less marked, was found along the margin of the tricuspid curtains. In view of these post-mortem evidences, the author felt confident that the fatal attack was endocarditis, and that the one of some months previous was probably the same. The writer is one of those who hold strongly the close relationship between rheumatism and chorea.

From the practical point of view, the importance of this subject turns on the treatment by rest when such pyrexial attacks are recognized in the course of chorea. But even after the pyrexia subsides the child should still be kept quiet for at least a few days. In this way it may at least be hoped that, by lessening the strain, the results of the injury done to the endocardium of the valves may be minimized, and serious damage may be thus avoided, or at least lessened.—*Arch. of Pediatrics*, July, 1890.

REPORT ON DISEASES OF THE NOSE AND THROAT.

BY C. H. KNIGHT, M.D.

Bronner (A.) on the Use of the Dental Drill in the Treatment of Deviations and Spurs of the Nasal Septum.—The mucous membrane is first painted with a twenty-per-cent. solution of cocaine, and five or six minims of the solution are injected under the mucous membrane at several places with a Pravaz syringe. A trephine with a smooth-cutting edge is used for cartilaginous outgrowths. In cases of exostosis, which are rare, the ordinary saw-edge trephine is used. Hemorrhage, especially when cocaine is used, is but very slight, and the pain is much less than with the knife or saw. After the operation the nostril is plugged with cotton soaked in glycerine and iodol, the plug being left in for five or six days. In cases of deviation more care must be taken to avoid perforation. Hartmann's flap operation, the base of the flap being posterior, is commended. The flap, being pushed back while the cartilage is being removed, is afterwards replaced. A thin piece of wood or metal, to hold the flap in place, is passed into the nostril, which is then plugged with wool.—*Jour. of Laryngol. and Rhinol.*, July, 1890.

Roberts (J. B.) on Submucous Resection of Cartilage in Deviations of the Nasal Septum.—In certain cases, owing to excess of tissue, the septum cannot be held in a straight position by means of retention pins after simple division. It is necessary to remove part of the redundant septum. Hitherto this has been done with the nasal punch, or knife, leaving an opening between the nares. The proposed operation obviates this objection. The occluded nostril is first dilated with finger or forceps. A long, curved incision, with its convexity downwards, is then made, and the flap is separated by a blunt elevator. An elliptical portion of cartilage of the required size is then cut out with a blunt tenotome, support being given to the

septum in the meantime and perforation being prevented by means of a finger passed into the opposite nostril. The segment of cartilage is then stripped up from the mucous membrane of the concave naris by means of a blunt instrument, the flap of mucous membrane is replaced and may be held in position with one or two sutures of catgut. The operation is readily performed, gives rise to no great hemorrhage, and gives satisfactory relief in many cases of nasal obstruction.—*The Coll. and Clin. Record*, June, 1890.

In the *Lancet*, June 28, 1890, the following rather heroic operation is described by Mr. Clinton Dent. The patient was a boy, aged seven, with marked disfigurement and almost complete occlusion of the left naris due to congenital deviation of the septum.

The first steps were precisely the same as those of an ordinary Rouge's operation. A free incision was made along the line of reflexion of the mucous membrane beneath the upper lip; then the attachments of the alæ of the nose on both sides to the superior maxilla were rapidly separated with the scissors, and a horizontal cut freed the connection of the cartilaginous septum below. By drawing up the now detached soft parts of the nose a good view of the interior was obtained. A vertical cut was next made with fine bone-cutting forceps well back in the septum, and it was then found easy to press the loosened plate towards the patent side of the nose. A single suture, passed through this piece of the septum and the cut parts below just to the right of the median line, was required in order to maintain the septum in its new position. In replacing the cartilaginous alæ and the soft parts of the nose care was taken to draw them over to the left side. Thus a species of "autoplastic par glissement" was effected, the septum after division being shifted in one direction and the soft parts in the other. The little finger could now with ease be passed from the anterior along either side of the septum right back to the posterior nares, and it was evident that the passage was perfectly clear on both sides. The inferior turbinated bone was also removed in great part. Two pieces of drainage tube, united by a silk thread in front, were pressed into the nostrils to maintain the patency of the passages, and the soft parts were kept in position by a second suture and strapping applied across the face as after operation for harelip. A pad was also strapped so as to apply pressure to the side of the nose. The eyes were closed by pads and bandage for the first twenty-four hours.

Bliss (A. A.) on Three Cases of Occlusion of the Nares by Deflection of the Nasal Septum.—The points of interest in these cases are the extent of the deformity, one nostril in each case being almost or quite occluded, and the marked relief given by operation. The main features of the operation are separation of the triangular cartilage from the vomer and the anterior nasal spine by means of Allen's septum knife, and retention of the septum in a relatively straight position by means of a steel pin, passed from the concave side of the septum across its convexity, its point being buried posteriorly near the junction of the vomer with the perpendicular plate of the ethmoid. The pin is reinforced by a plug of bichloride cotton. The plug is renewed daily. In the first case the pin was left in ten days, in the second it was removed on the fifth day on account of the irritation it produced, and in the third case no pin was used, the septum being retained in its new position by pledgets of lint and bichloride cotton, continued for three weeks. In no case was the septum made absolutely straight. The pin should be closely watched as it is apt to produce irritation. It is often necessary to saw away the long hyperostosis remaining at the junction of the vomer with the triangular cartilage after the septum has been forced more nearly to the median line.

(Too much stress cannot be laid upon the author's caution regarding the pin. The reporter has met with two cases in which the pin has cut its way through the cartilage, leaving a permanent opening. In one the pressure was excessive, the cartilage not having been sufficiently released; in the other, a recent case, there is reason to suspect the existence of a tubercular diathesis.)—*Univers. Med. Mag.*, July, 1890.

Cartaz (A.) on Certain Complications of the Operation for Adenoid Tumors of the Naso-Pharynx.—Two complications are discussed:

(1) Hemorrhage.

(2) Infectious or inflammatory accidents (pharyngitis, amygdalitis, suppurative otitis).

The cases, four in number, cited by Delavan, in which hemorrhage more or less alarming occurred, are reviewed, and six cases of his own and of other observers are described. The author admits the rarity of excessive primary hemorrhage. Among the possible causes he enumerates hemophilia, laceration of the pharynx or of the velum, especially when an anæsthetic is not used, recent inflammation of the naso-pharynx, and coincidence of the operation with the menstrual epoch. A fibrous consistence of the tumors, as met with in adults, may explain the hemorrhage in certain cases. It is impossible to precisely determine the source of the hemorrhage. Rhinoscopy is impracticable and digital examination is not satisfactory. Of the measures to check the bleeding the author prefers the injection into the nasal fossæ of cold, iced, or better still very warm water, to which may be added a styptic of some kind. If necessary the vault of the pharynx may be plugged with an antiseptic tampon charged with cocaine or some hemostatic.

The extent of surface denuded in operating for adenoids and the necessary exposure of the surface to the external air would lead us to expect frequent septic and inflammatory accidents, but on the contrary they are very rare. Slight febrile reaction and facial erysipelas have been noticed by some observers. The tonsil is a favorite seat of secondary inflammation, but in at least one instance was distinctly due to the manipulations required to check the hemorrhage. Otitis media is the most frequent complication, and among the causes which may produce it may be included over-exercise immediately after the operation, imperfect instruments, the neglect of antiseptic precautions, and the introduction of infection by the use of the finger-nail. The measures by which danger from these sources may be avoided are obvious.—*Arch. de Laryngol. de Rhinol., etc.*, June, 1890.

Baber (E. C.) on the Self-Retaining Palate-Hook.—The author uses White's instrument, and finds it very valuable, especially in catheterism of the Eustachian tube through the mouth. This operation, otherwise difficult, with the aid of the palate-hook becomes a simple and sure procedure, and may be accomplished with but little inconvenience to the patient. He has had constructed a metal catheter of peculiar shape and size, and gives a minute description of the way in which it should be used.

A splendid illumination of the naso-pharynx may be obtained by attaching a small incandescent electric lamp to the convexity of the hook, and if desired, the rays of light may be thrown forward into the nasal chambers by means of a small reflector placed behind the lamp. Whether this has any special advantage over the ordinary hook and method of illumination the author has not yet determined.

Two suggestions of practical value are made:

(1) A ten-per-cent. solution of cocaine should be used, and it generally suffices to let a few drops run through the anterior nares over the posterior surface of the velum. Should this not produce enough anæsthesia the cocaine may also be painted up behind the soft palate.

(2) After the hook has been introduced the patient is directed to close his lips and breathe through the nose. Thus the velum becomes relaxed and may easily be drawn forward. To get a satisfactory view the traction should be considerable.

One would imagine that rhinoscopy is to be revolutionized by the palate-hook. No doubt posterior rhinoscopy is in many cases a manipulation requiring "skill and perseverance." In rare instances no view can be obtained without considerable training of the patient, and in just these cases the palate-hook is intolerable. In other words, in the very cases in which we most desire it we find it most difficult and often impossible to apply.—*Brit. Med. Jour.*, June 28, 1890.

Mackenzie (G. F.) on a Case of Sarcoma of the Tonsil.—This case is of interest because of the remarkable similarity in appearance between the disease in its early stages and chronic inflammatory enlargement. The patient was a man twenty-three years old, in bad general condition, whose father had died of pulmonary tuberculosis. The early symptoms were pain, of but slight degree, and swelling on the right side of the throat. By the time a correct diagnosis was possible glandular infiltration had become so extreme that removal of the neoplasm was considered impracticable. The patient died of exhaustion within five months. The following microscopic appearances were found:

"On section the tumor appeared pale in color and firm in texture; it did not show any appearance of being divided into lobules. Examined microscopically, it was seen to be composed almost entirely of rounded cells, with little or no intercellular substance. Scattered throughout the tissue there were seen here and there irregular masses and bands of a homogeneous material, evidently the remains of a pre-existent tissue which was undergoing hyaline degeneration. A few blood-vessels were found undergoing obliteration, with thickened and degenerated walls, and contents composed of altered blood-corpuscles and fatty globules. The tumor was evidently a large, round-celled sarcoma."—*Brit. Med. Jour.*, Jan. 21, 1890.

Downie (W.) on a Case of Primary Epithelioma of the Left Tonsil.—The earliest symptom in this case, which was that of a man forty-five years old, was itching pain in the left ear. In the course of a month the pain was referred distinctly to the faucial region and was aggravated by swallowing, the pain shooting sharply up towards the left ear during deglutition. In the course of six or eight months the surface of the tonsil became ulcerated, the ulcer including the margin of the anterior pillar. The glands beneath the angle of the jaw on the left side became indurated and painful. The surface of the ulcer was elevated, hard, indurated, and slight manipulation caused bleeding. There seems to have been no operative interference.—*Glasgow Med. Jour.*, July, 1890.

Wright (J.) on Salol in Acute Tonsillitis and Pharyngitis.—In his observations on the use of this drug the author has divided his cases into three classes: (1) those in which treatment was begun on or before the second day, twenty-one in number; (2) those in which treatment was begun on the third day, fourteen in number; and (3) those in which treatment was begun after the third day, fifteen in number. He finds ninety grains daily, given in ten-grain doses in powder or emulsion, a sufficient quantity to relieve the throat symptoms without producing disagreeable effects. He has no faith in its local action. It is most effective in lacunar tonsillitis, less so in catarrhal pharyngitis, and least in a well-developed quinsy. The relief from pain was in most cases very marked, in one case of peritonsillar suppuration the local swelling decidedly increasing after the pain had entirely subsided. A similar phenomenon has been noticed by Gouguenheim, with whose conclusions the author fully agrees:

1. Salol acts beneficially in acute anginas of whatever cause.
2. It quiets the pain and dysphagia with the greatest rapidity.
3. In quieting the pain it may shorten the duration of quinsy.
4. It lowers temperature.
5. In nearly all cases it diminishes the duration of the angina.
6. In order to attain these results the dose should not be less than four grammes (sixty grains) daily.—*Am. Jour. Med. Sci.*, Aug., 1890.

Van Gieson (I.) on the Pathology of Laryngeal and Other Crises in Tabes Dorsalis.—The author bases his paper on the study of a case of tabes, which proved fatal during a laryngeal crisis, and in which was found chronic neuritis of the roots of the vagus and accessory portion of the eleventh nerves on both sides. He divides laryngeal crises into two forms (1) spasmodic and (2) paretic. In the first some of the attacks, probably the earlier and milder ones, are purely spasmodic. The larynx is normal. Attacks may recur over a period of months or even years. The paretic variety includes most of the recorded cases, and the crises are due to a paresis or paralysis of the abductors, although it may be that both adductors and abductors are weakened, the latter being especially impaired. The author hesitates to accept Semon's well-known theory of special proclivity to paralysis on the part of the laryngeal abductors, and seems inclined to accept the mechanical theory advocated by Gowers and others.

Experiments show that the equilibrium of the glottis inclines in favor of the adductors in the normal larynx (except in conditions like ether narcosis), and if the adductors are stronger in the normal larynx under ordinary circumstances, we should expect their strength still more prominently asserted in the disturbed equilibrium of the glottis, when both sets of muscles are paretic, for the subtraction of a given amount of absolute power from each set of muscles would diminish the action of the abductors in a greater ratio than the adductors, which are larger, stronger, and work at the glottis from a better mechanical standpoint.

The suddenness of the attacks is explained as follows, and the explanation is supported by the fact that many cases are benefited by reducing the faucial, pharyngeal, and laryngeal reflexes by means of cocaine and bromides:

The neuritis causes a (nearly equal) reduction of absolute power in both the constrictors and dilators of the glottis, which renders their equilibrium so unstable that with the slightest reflex or direct motor impulses the adductors, working on a superior mechanical vantage ground, gain the ascendency, and a crisis results. In other words, the exciting cause of many of the crises of this form, is a reflex or direct impulse sent through the recurrent nerve to a paretic, unstable group of antagonistic muscles with the balance of power in favor of the adductors, operates like the stimuli of the recurrent nerve in the experiments of Semon and Horsley. This excites a spasm of the adductors, which is intensified or prolonged and induced the more readily, perhaps, from the impairment of the function of the abductors being greater than that of the adductors, although both sets of muscles are paretic to a nearly equal extent. When the adductors become fatigued by their tonus, or should a condition like ether narcosis occur from the attack, the crisis gradually ceases.

This paper contains a review of the reported cases and a summary of the lesions found.— *Jour. Nerv. and Ment. Dis.*, July, 1890.

REPORT ON THE DISEASES OF WOMEN.

BY J. S. HAWLEY, M.D.

Harris (R. P.) on the Results of the Porro-Cæsarean Operation in All Countries, from Its Introduction to the Close of 1888.—The value of a chronological method of recording is proven by the clearly-established fact shown therefrom, that in all countries, with the exception of France, in which there have been twelve or more operations there can be exhibited a growing improvement in the results attained. Thus, there were six deaths following the first seven Italian operations, and only seven deaths after the last thirty. Italy saved 20 out of her first 46 cases, and 27 out of the next 45. Austria saved 17 out of her first 30 cases, and 25 out of the balance; her second, 30. Following her last 20 operations there were but 2 deaths, or 10 per cent. The early record of Germany was so discouraging that out of it grew the Sänger-Cæsarean method and its modifications. The first 7 cases were all fatal, and but 6 recovered out of 22, or the first half of all those in her credit. Of the second 22 there were 17 recovered; and of the last 15 only 2 died from the operation, a third death having been suicidal. England lost 7 out of her first 8 cases, and then saved 2 in succession. Mr. Tait claims to have had three additional operations without a death, but has not reported the cases; which would enlarge the credit of England to 15, and her recoveries to 8. This would have been a very remarkable success in the early days of the operation, but is much less so now. The late Professor Breisky performed his first operation in Prague on July 9, 1878, and his eighth and last in Vienna on September 28, 1888. Not one of his eight operations, covering more than ten years, had a fatal termination, and all of the children were living. Dr. Hubert Riedinger, of Brünn, also aided in a remarkable manner in establishing the credit of Austria. His first operation preceded that of Professor Breisky by twelve days, and his seventh was nine days before the eighth of Breisky. The seven women recovered, and but one child was lost. Up to the last of December he had not performed an eighth operation. France, as already mentioned, has not improved her record by experience. On the contrary, she has retrograded. The first five operations saved three women and three children; the second five, one woman and five children; the third, one woman and two children, and the two additional saved one woman and two children. There has not been reported one French Porro case belonging to the past four years, and the operation would appear to have been abandoned by its early advocates.

Seventeen operations belonging to the last four years, ending on December 31, 1889, have been reported to me in answer to letters, of which four terminated fatally. The records of these four years are respectively as follows: 1885—24 cases, 7 deaths; 1886—23 cases, 4 deaths; 1887—18 cases, 5 deaths, 1 suicide; 1888—28 cases, 4 deaths. Of the first 50 women out of the 264 cases recorded 30 died as the result of

the operation; and of the last 50 but 10, a reduction of the death-rate from 60 per cent. down to 20.

Of the whole 264 women 117 died from the operation, divided as follows: 74 out of the first half, that is, 132, and 43 out of the second 132. Thus it will be seen, under several forms of calculation, that the Porro operation of to-day, under proper management, is far less fatal than that of five years ago, as in 1884, when 17 women died out of 29, or nearly 58 per cent.

As the day of experiment has passed, and the technique of the operation has been established by experience, there is no reason why there should not be a large percentage of cases saved—certainly 80 per cent.—and with due care as to time of operating and condition of strength in the patient, even more than this. The operator ought to be able to make a prospective prognosis in a given case, and should, if possible, so order the preliminary steps that "unfavorable" will not have to be written in rating the prospects of the patient. It is a well-established fact that few cases rated as "favorable" before the operation have died, and that still fewer marked as "unfavorable" have not. The respective credits of the several countries in which the Porro operation has been performed (not including that of 1889) stand as follows:—

No.	Country.	Cases.	Saved.	Lost.	No.	Country.	Cases.	Saved.	Lost.
1	Italy . . .	91	47	44	8	Belgium .	5	3	2
2	Austria . .	60	42	18	9	Scotland .	5	1	4
3	Germany .	44	23	20*	10	Switzerland	6	5	1
4	France . .	17	6	11	11	Australia .	2	2	0
5	England . .	12	5	7	12	Holland .	1	1	0
6	Russia . .	10	8	2	13	Spain . .	1	0	1
7	United States of America	8	2	6	14	Mexico .	1	0	1
					15	Japan . .	1	1	0

* And 1 suicide.

It is proper, in this connection, to state the results of the conservative Cæsarean section up to the same date, January 1, 1889, as many may be under the impression that the Porro operation is quite equal to it in its ability to save life. Like the latter, the new method of performing the old Cæsarean section is also passing through a stage of diminishing mortality, and there is a very marked contrast for the better between the work recently done and that of the years 1882, 1883, 1884, and 1885; and particularly is this the case in the United States of America. Out of the first 20 cases operated upon in all countries, there were 9 deaths; out of the second 20, there were 6; and of the last 40 in 1888, there were only 6. The following table will show the operations in contrast:—

No.	Country.	Cases.	Saved.	Lost.	No.	Country.	Cases.	Saved.	Lost.
1	Germany .	94	81	13	7	Holland .	9	9	0
2	Austria . .	32	26	6	8	England .	3	1	2
3	United States of America	26	11	15	9	India . .	2	1	1
4	Russia . .	10	7	3	10	Switzerland	2	1	1
5	France . .	4	2	2	11	Denmark .	1	1	0
6	Italy . . .	4	2	2	12	Norway .	1	1	0

There were 57 operations in Europe in the year 1888, with 7 deaths; and 13 in the United States of America, with 8 deaths. There have been 34 operations in America, with 18 deaths.—*Brit. Med. Jour.*, Jan. 11, 1890.

The Placenta in Arrested Pregnancy.—Obstetricians have long admitted that portions of retained placenta may remain alive and develop into placental polypi. The growth of the placenta in ectopic gestation, after the death of the fœtus, has been observed by several authorities. Dr. Chaput, of Paris, has reported in the *Bulletins de la Société Anatomique de Paris* two cases where the placenta lived after arrest of normal pregnancy. In the first, abortion occurred at the second month, and the placenta was retained for two months. In the second case, the fœtus died at the third month, and was retained, with its placenta, for two months longer. The child and its appendages were removed, with fatal results to the mother. Both patients were multiparæ, and over thirty-five years of age. The placenta in neither case had atrophied, nor continued to develop as in normal pregnancy. A singular abnormal development was detected. The villi had decreased greatly in number, and had lost their vessels; but those remaining had increased from two to ten times their normal size, and contained numerous cells some very large, without distinct nuclei. The villi retained an epithelial lining. Dr Chaput takes care to remind his readers that, although science proves that retained placenta does not necessarily die and decompose, the results of retention are not on that account less serious. Both of his

cases suffered severely, with most of the usual symptoms. His observations, he further insists, do not prove that the placenta can go on developing indefinitely; nor can we feel sure that it will perish by gradual atrophy rather than by more or less sudden decomposition. In all cases a retained placenta ought to be removed.—*Brit. Med. Jour.* (Editorial), May 17, 1890.

Prolapse of the Urethral Mucous Membrane in Old Women.—A paragraph on this disease as observed in female children appeared in the *Journal* of April 12th. Dr. Södermark, of Boras, Sweden, has described two cases of prolapse in old women, in *Hygiea*, vol. li. Three cases of the disorder, one in a child, came under his notice within three years, and he expressed surprise that it is usually described as very rare. He found that the disorder caused great discomfort. In one case, the patient was fifty-eight years old, and was also subject to prolapsus uteri, cystocele. and rectocele. A fleshy mass, the size of a walnut, partly sloughing, occupied the site of the urinary meatus. In the midst of the mass, a depression led into the urethral channel. The entire outgrowth was removed with the galvano-cautery, whilst the vagina was narrowed anteriorly and posteriorly by a plastic operation. The result was satisfactory. The second patient had reached the age of seventy. For several years a swelling the size of a plum, consisting of the mucous membrane of the urethra, projected from the meatus. It was successfully removed with the galvano-cautery. The child was nine years old, younger than any of the cases described by Dr. Benicke in the paragraph above referred to. The prolapse also consisted of the urethral mucosa. It was removed with scissors, and the edges of the raw surface left behind were united by sutures. Thus prolapse of the urethral mucous membrane is not unknown in age and childhood. How frequent it may relatively be in adult life is an interesting theme for experts in gynæcology to determine. As to treatment, opinion is divided, for some have found that the cautery causes more cicatricial contraction than the knife or scissors, whilst some are led by experience to an opposite conclusion.—*Brit. Med. Jour.* (Editorial), May 17, 1890.

Abdominal Surgery in Cuba.—According to Dr. Barrena, the results of abdominal surgery, as practised by himself and some of the other leading surgeons in Cuba, have hardly been as satisfactory as could be desired. Of 39 cases of ovariotomy, 12 were fatal. Of 11 cases of hysterectomy, no less than 9 were fatal; 3 cases of miomotomy, 3 of salpingotomy, and 1 of ligature of the tubes, were all successful, but 4 cases of exploratory incision proved fatal to three of the patients, and the only case of vaginal hysterectomy was also fatal. Altogether, out of 62 patients operated on, no less than 25 died. It is to be hoped that this courageous statement of actual facts may tend to deter surgeons, who might otherwise be induced by the brilliant results of abdominal operations frequently published, from entering with too light a heart upon operations of this nature. The unfavorable results referred to may, perhaps, be partially explained by the insanitary condition of Havana, and probably of other Cuban cities. This subject was also treated during the Congress by Dr. Wilson, who pointed out that the bad water and the want of a proper system of sewerage, together, doubtless, with the heat and moisture of the climate, raised the death-rate of Havana to a figure about double that which denotes the death-rate of London.—*Lancet* (Editorial), April 4, 1890.

Williams (J. D.) on Accessory Fimbriated End of the Fallopian Tube.—This was removed from a patient that died of cerebral hemorrhage at the Royal Infirmary in June, 1889. She was fifty-five years of age, and had borne several children. The right tube, to which the accessory orifice is attached, was 11.2 cm in length. The portion of the tube between the two openings was about 1.3 cm in length, and was much narrower—only measured half a centimetre in width—than that on the uterine side of the secondary opening, which measured 1 cm. There were two or three small pea-sized cysts in the serous covering of the tube. The lumen was normally patent. The veins of the broad ligament were quite healthy.—*Edinburgh Med. Jour.*, April, 1890.

Lea (Henry) on Syphilitic Affections of the Uterus.—Case 1.—Several years ago Mr. Cadge, of Norwich, sent to this hospital a gentleman and his wife. The wife had repeatedly miscarried. They both went through a mild, sustained course of mercury. After this they had healthy

children ; after a time, however, they came again, when the wife had again repeatedly miscarried. She then went through a second mercurial course, and then again had a healthy child. Whether there were any more children I have not had the means of ascertaining.

Case 2.—The wife of a gentleman who had previously been under my care for syphilis came with a most irritable and distressing rash over the lower part of her body and in the axillæ. The eruption was composed of a very large number of minute red pimples, and the intervening portions of skin were also red. This condition gave her no peace day nor night, and made her life almost intolerable. It had existed for some weeks, and, as happened in the following case, she could not refrain from scratching. This lady informed me that she had been under a very prolonged treatment for disease of the womb, and for weeks together occasionally had kept her bed with profuse menorrhagia. Two of her children had been treated for hereditary syphilis before they attained the age of puberty. After a sustained course of mercury, which she thoroughly carried out with the assistance of her husband, who had undergone the same treatment, she appeared perfectly cured, and subsequently had a very fine, healthy child.

Case 3.—A lady, who had been under very prolonged treatment for displacement of the womb, came under my care for a most distressing irritation on the lower part of the body. This was accompanied by a profuse eruption of bright-red pimples, from which a transparent fluid exuded. This irritation had long continued, and had made her life quite miserable. She felt as if she "could scratch herself to pieces." Her husband, who had been previously under my care, and two of her children were treated for syphilis. Both before and after the appearance of the eruption she had constant aching and sense of bearing down in the back, accompanied by a chronic discharge. Any pressure in the neighborhood of the womb gave pain. Under a mild course of mercury, lasting for three months, her symptoms disappeared, and she considered herself quite well, but for some time slight brownish discolorations came on the face. These were persistent for a time, but have now entirely disappeared. The children which she had after the mercurial course were comparatively healthy. In all these cases, with the exception of the children, the mercury was given by means of the calomel bath. The action of this upon a patient's system is regulated by the quantity of calomel used in each bath. As a rule, the bath should be used every night, so that the action may be sustained. This requires to be especially noted, because I find that in some institutions where the calomel baths are supposed to be administered, one, two, or three baths a week are often deemed to be sufficient. But a more serious evil than this sometimes occurs, a sweating bath is given in addition to the calomel bath. The sweating weakens the patient and washes off the calomel. In one instance I have direct evidence that the sweating baths were given as calomel baths without any calomel at all. Short inhalations of the vapor of calomel increase the efficacy of the baths ; but if this is done it should be when the vapor is thoroughly mixed with common air, and the calomel used should contain no free hydrochloric acid ; this irritates the mucous membranes. If calomel, as usually obtained, be sublimed, and a piece of moist litmus paper held in the vapor, it will indicate the presence of a free acid. When pure calomel is used, and inhalation is not desirable, one or two drachms may be used at each bath to begin with. It is of great advantage if the patient can sleep in the cloak used for the bath. If taken in the bedroom, if small, this should be fairly ventilated.—*Lancet*, July 5, 1890.

Oliver (James) on Sudden Extroversion of the Vagina in a Nulliparous Female.—It is but rarely that one witnesses complete extroversion of the vagina in single and nulliparous females during early life. Under any circumstances this condition of affairs is very seldom suddenly produced.

A. B., aged twenty-one, a single and mulliparous female, stated that menstruation was established at the age of fourteen, and had always recurred regularly and had been free from any associated disturbance. Fourteen days before attending, whilst apparently in her usual good health and without having previously experienced any sensation of "bearing down," she lifted a heavy box with both hands and immediately was seized with intense "bearing-down" pains ; locomotion increased the discomfort, and it was impossible for her to sit down except on the edge of a seat, and even this was painful. She had neither at

the time of nor since lifting the weight experienced any trouble in passing water.

The vagina was completely extroverted; the cervix uteri was directed forwards, and the fundus, which was extruded beyond the external genitals, was readily detected posteriorly towards the anus. The mucous membrane of the cervical canal was everted —apparently—to the extent of half an inch, so that the nose of the cervix itself was equal in size to a five-shilling piece. A sanious discharge was exuding from the everted mucous membrane of the cervical canal. The mucous membrane of the vagina was dry and thickened, and much excoriated in consequence of the exposure and friction. The whole mass protruding from the external genitals was extremely tender to the touch, and was with difficulty replaced.—*Brit. Med. Jour.*, March 1, 1890.

Baldy (J. M.) on Gonorrhœal Diseases of the Uterine Appendages.—The author, after careful review of the literature of this subject, especially of that which relates to the influence exerted by the gonococcus as an ætiological factor in the diseased conditions discussed, and from additional evidence drawn from his own experience, concludes as follows:

1st. The gonococcus is merely the result of a gonorrhœal inflammation; never the cause of it.

2d. A true gleet, or so-called latent gonorrhœa, is non-infectious and will not cause a gonorrhœal inflammation.

3d. An acute or subacute gonorrhœa only will cause a similar disease in the female, and consequently set up a specific pelvic inflammation.

4th. The "latent" form of gonorrhœa, as taught by Säenger and others is a myth.

5th. By far the most frequent cause of pelvic inflammatory disease in women, is puerperal sepsis.

6th. Gonorrhœa is the cause of not more than one fourth of these inflammatory processes in women.—*Med. Age*, June 25, 1890.

Taylor (Wm.). History of an Abdominal Ligature.—This contained the history of a patient — from whom both ovaries were removed, the left being cauterized and the right ligatured—from the time of the operation till her death. Dr. William Russell read the pathological report of the case. The left pedicle, which was cauterized, represented normal healing. The right pedicle, which was ligatured, was altogether different in appearance. It was thickened and indurated, and had similar tissue immediately behind it, which further extended downward to the pouch of Douglas and invaded the wall of the rectum in the same way. This thickening also extended upward in front of the spine and surrounded the lower part of the right ureter, while the left ureter was completely surrounded by this indurated tissue, and caused hydronephrosis of the left kidney. Laterally it extended into the supra-renal capsules, obliterating the left and implicating the right. The pancreas was also implicated and much indurated. In the large omentum was a nodule, and at the cæcum was a hard dense mass of the same tissue. The bladder was normal. There were several nodules in the liver, one a scirrhus. The nodule in the omentum might be called a "fibro-adenoma," and the tissues round the ureters were of the same character. Dr. Russell was of opinion that the irritation of the ligature had caused the formation of this indurated thickened tissue, and had finally led to malignancy.—*Med. Press*, June 11, 1890.

Collins (E. T.) on Pathological Objections to Curetting the Uterus in Puerperal Fever.—A recent suggestion to curette the uterus in puerperal fever appears both unnecessary and pathologically unjustifiable. This fever is a septicæmia, in no way specific or different from general wound sepsis, and may be said to occur as sapræmia or as septic infection.

In the sapræmic form the putrefactive germs admitted into the genital tract during labor rapidly multiply in the lochial discharges (themselves innocuous) and in the contused or abraded mucous surfaces. These special germs of putrefaction are saprophytic and speedily perish in the blood, and are powerless to attack living tissues. The discharges become offensive, and if partially retained give rise to constitutional symptoms. It is, however, only the chemical products and not the organisms themselves that invade the system and cause the sapræmic form of puerperal fever, the intensity of which is directly proportionate to the dose of chemical poison absorbed. If the dose be a large one, the most severe symptoms of acute septic poisoning may set in and rapidly culminate in death. Certain post-mortem appearances are found, but no micro-organisms have been discovered in the blood, and the blood is not infective. The onset of the fever is indica-

ted by a more or less rapid rise of temperature. There is usually no rigor, and the disease is non-infective. The obvious treatment is to remove the putrefactive material supplying the poison, and this can be done efficiently by intra-uterine antiseptic irrigation, inasmuch as the bacteria do not exist in the living uterine tissues. Curetting alone is useless, and if with irrigation unnecessary; and further, by creating a fresh breach of surface for absorption, may be an actual source of danger. Curetting can only be of service for the removal of portions of putrefying placenta or decidua.

In the second form, or septic infection, micro-organisms again play an active part, but are pathogenic. They invade the living tissue and increase in the blood, causing fever of a well-known intensely contagious type. The nature of the virus is unknown, and though micrococci and streptococci have been found in all the organs secondarily affected by puerperal fever, they do not exist as a separate species like the tubercle bacillus or bacillus subtilis. The germs are introduced into the genital tract by the surgeon's hands or instruments; and should putrefaction of the lochia coexist, they find a suitable nutrient material for development, or attack the injured tissues whose vitality and resisting power are lowered. They invade the system through the lymphatic or venous channels, or by extension along the planes of connective tissue. The constitutional fever may be accompanied by localized pelvic cellulitis or pelvic peritonitis, or by acute septic infection of the whole peritoneum (diffuse peritonitis) and distant complications. The local uterine affection may be insignificant and not indicated by the lochia, death resulting from acute disintegration of the blood causing collapse. "The condition of the lochia is not of any diagnostic or prognostic import; it merely indicates the state of the inner surface of the uterus, and not always that. Altered uterine surface need not reveal itself in altered lochial secretions, and serious diseases may be present where the flow appears healthy, while decomposed lochia do not always prove that infection has occurred."

Infected puerperal fever is ushered in by a rigor more or less severe, followed by elevation of temperature, indicating the invasion of the system by the virus of infection. Here it is needless to point out the inutility of curetting. Once systemic septic infection has occurred no local treatment whatever will prevent the multiplication of the virus in the blood; nor do we possess any specific able to counteract or destroy the infective organisms so admitted. Thorough antiseptic irrigation of the uterine cavity and vagina alone avails, and even this ceases to be of much importance after a few days.

Beyond, therefore, thorough asepticity of the hands and instruments during labor, and of antiseptic syringing of the vagina, both before examination and after parturition, especially important when discharge of meconium has occurred, we have no direct operative means of preventing septic intoxication or infection. When this has been done, Spiegelberg declares it "bad practice to irrigate," except on the definite indications of putrefying matters in the parturient tract or the supervention of pyrexia.

The basis upon which the suggestion to curette is founded, that of an analogy between the puerperal uterus and chronic endometritis, is by no means a good one. It should be rather compared to a large flesh wound, as an amputation or compound fracture.—*Lancet*, Jan. 18, 1890.

Edis (R. E.) on the Diagnosis and Treatment of Metrorrhagia.—Every one engaged in the daily routine of practice, must frequently have met with cases of severe uterine hemorrhage which puzzled him not a little, both as to their diagnosis and treatment, and caused him much anxiety and worry at the time, and possibly led to much unpleasantness. With the hope of throwing some light upon the nature of these difficult cases, I offer the following remarks, trusting they may prove of service to some. Of all the organs of the body, the uterus alone is subject to periodical hemorrhages as a natural physiological process during some thirty years of the individual's existence. This function is influenced by many and various conditions, both general and local, often exceedingly difficult to understand. Metrorrhagia must not be regarded as a disease of entity *per se*, for which one method of treatment is applicable, nor is it necessarily an invariable evidence of disease, for it may be merely an expression of constitutional or general vascular tension, the uterine mucous membrane acting, so to speak, as a safety valve, the hemorrhage being positively beneficial, and affording us a useful

hint as to treatment. Speaking generally, the most frequent local cause of metrorrhagia will be found to be threatening miscarriage; retained products of conception from incomplete abortion, or retention of a small portion of placenta; subinvolution, with granular erosion or laceration of the cervix uteri; villous endometritis; hæmatocele; new growths in the form of polypi, fibroids, or malignant disease of the fundus or cervix uteri; retroflexion of the uterus, with or without prolapse of one or both ovaries. As to the treatment, a correct diagnosis being the first and most important element of treatment, it follows, as a matter of course, that having ascertained the cause, we know then what our plan of action should be.

When uterine hemorrhage persists, notwithstanding the employment of constitutional measures, and there is no apparent local cause to account for it, we should, without further delay, dilate the cervix uteri and explore the interior of the uterus.

Numerous instances have been recorded of patients dying from uncontrollable hemorrhage, where a *post-mortem* has revealed the existence of some intra-uterine growth, as a polypus, or sub-mucous fibroid, retained product of conception, which could readily have been removed or dealt with had appropriate measures been adopted in time, and the patient's life thus saved.—*Provin. Med. Jour.* (slip not dated), p. 443.

Miller (K.) on Vaginal Irritation as a Cause of Bladder Symptoms in Young Girls.—More common even than enuresis among girls is a form of irritability of the bladder manifesting itself chiefly in an inability to retain the urine in a normal manner. It is often complained of in school-girls, who are obliged to leave the school-room even between intermissions in order to pass the urine, else the bladder, spasmodically contracting, empties itself in spite of every effort of restraint. Even with the promptest attention to its demands these girls are occasionally subjected to the mortification of wetting their clothing. Oftentimes no complaint is made of any other symptom than this annoying vesical irritability. The condition is more common at the age of six to twelve or fourteen years, but may, if untreated, persist indefinitely. Examination reveals an extremely sensitive and hyperæmic condition about the vaginal orifice, and further investigation will show the extension of this tenderness within the vagina. Often this latter investigation can only be made by the use of an anæsthetic, not only because of the small size of the parts, but because of their extreme sensitiveness. Whatever the cause, the treatment must be directed to the removal of the vaginitis, when the bladder will recover its tone. Cleanliness must be enjoined. Not only is careful washing needful, but warm hip baths are of value. Soothing powders must be dusted on, the vulva being opened as far as possible, and children old enough to understand the aims of the procedure will generally submit to the application at night of a small pledget of absorbent cotton wet with a healing lotion containing pinus canadensis, hamamelis, carbolic acid, or similar remedy, diluted with thin boiled starch. Where the urine is normal, rhus aromatica has proved a valuable aid in controlling the habit of irritability of the bladder and relieving the symptoms till the cause can be removed.—*Jour. Am. Med. Assn.*, June 17, 1890.

REPORT ON DISEASES OF THE EAR AND EYE.

BY A. T. MUZZY, M.D.

West (Geo. R.) on Suppuration of Mastoid Cells; Operation; Complete Recovery.—A blacksmith forty years of age, with strumous history, was attacked by abscess of middle ear. After a month of fluctuating progress swelling and great tenderness over the mastoid indicated the spread of the suppuration to this region. Under ether a 5-16 trephine removed a soft button of bone and liberated a quantity of pus. All inflammatory symptoms immediately disappeared under proper antiseptic treatment, and the hearing of the ear was fully restored.—*Dixie Doctor*, April, 1890.

Williams (A. D.) on Rupture of Drum by a Blow in Sparring.—An accidental blow over the ear in friendly sparring produced some pain, with deafness and numbness of side of the head. Examination three hours after injury showed a line of rupture and a swollen membrana tympani from hemorrhage into middle ear. Great sensitiveness prevented use of inflation with the aim of blowing blood out through rupture. Antiseptic and anodyne solution was prescribed, to be dropped

into ear. Two days afterwards wound still inclined to bleed, indicating that if the blood had been removed at the previous sitting, fresh hemorrhage would have re-established the previous condition. The ear will be permanently injured and noise may be permanent.—*St. Louis Med. and Surg. Jour.*, June, 1890.

Cousins (J. W.) on New Antiseptic Artificial Membrana Tympani.—These aids to hearing are of service in certain forms of ear disease that are clearly marked. (1) In perforation; here the amount of benefit can only be told by experiment. (2) In abnormalities of tension, as cicatricial collapse, thickening, or atrophy of drumhead; in fact, all cases of accommodative loss from alterations in the contents of the tympanum, provided the Eustachian tube is unobstructed and the naso-pharynx fairly healthy. The new membrana submitted has the shape of a conical hat with tall crown and flat brim. It is of different sizes and made from compressed cotton fibre. It weighs from $\frac{1}{8}$ to $\frac{1}{4}$ of a grain. They can be made vehicles of medication. They should be removed during the night for cleaning both ear and contrivance itself. As a rule the artificial drumhead gives most satisfaction in cases of perforation.—*Times and Register*, May 3, 1890.

Smith (W. F.) on a Singular Case of Injury; Blindness from a Penetrating Wound of Cheek and Orbit.—A boy twelve years old, immediately on receipt of injury, from the tine of a pitch-fork, noticed blindness of the eye by closing the other. The direction of the wound was from a point just above the alveolar process of the superior maxillary bone over the second molar tooth, backwards and inwards. No pain was complained of, no suppuration from the opening occurred. The ophthalmoscope showed no disturbance of the fundus. The pupil was dilated. Taking a skull and using a letter opener, the indication was a crushing of the optic nerve at its entrance through the spheno-maxillary fissure. Three subsequent examinations show no change, no symptoms further than complete loss of vision.—*Arch. Ophthal.*, April and July, 1890.

Groenow (A.) on Nodular Opacities of the Cornea.—The name keratitis punctata is used for the different forms of punctate and nodular opacities of the cornea, whether they are stationary or the manifestation of a recent keratitis. Nearly every author gives it a different construction. A picture of the nodular form would be the following: during the whole period of observation, of indefinite length, save an accessory catarrhal conjunctiva, no florid process is visible—rather a stationary condition. The opacities consisted of sharply defined gray dots that did not exceed $\frac{1}{4}$ mm in diameter and were thickly scattered, did not become confluent, and were separated from each other by healthy corneal tissue; between these larger nodules lay smaller, dust-like gray dots more numerous than the others. The opacities occupied almost exclusively the central portion of the cornea, and the superficial, together with the epithelial layer. The larger formed protuberances on the surface of the cornea and disturbed vision very much. When the cornea was scraped the opaque places were found firmer than the epithelium. They doubtless develop very slowly, seem not to overstep a certain limit, and never retrograde spontaneously. All treatment is comparatively useless; scraping of the epithelium produces occasionally a certain amount of improvement in vision temporarily. These nodules are most likely epithelial proliferations, perhaps also cicatricial tissue. They belong to the same group as the cases of so-called ribbon keratitis.—*Arch. Ophthal.*, April and July, 1890.

Abadie (Chas.) on Pathology and New Treatment of Sympathetic Ophthalmia.—Genuine sympathetic ophthalmia resulting from traumatism is a microbian disease of infectious origin. The transmission is through the optic nerve and chiasm. The therapeutic agent may not be antiseptic, or the edges of the wound may not lie evenly and closely; the microbes, invading thus, reach the deeper parts, and by the channels already mentioned reach the fellow eye and produce their disastrous results. The old empiric procedure of enucleation is by this explained and the reason why it was sometimes successful and at others a failure. If done in time all agree that enucleation prevents the sympathetic trouble. The process of saving the good eye is enhanced by use of mercurial germicides. When an eye is seriously injured, and seems not to be wholly lost, and the question of enucleation is proposed, we now may avoid enu-

cleation. First, by strict antisepsis infection is sought to be avoided; if, in spite of our care, infection takes place, the wound is thoroughly cauterized under the influence of chloroform. If infection still proceeds, the eye is to be injected with one or two drops of a 1 to 1000 bichloride solution. These injections cause considerable irritation for some hours, but this gradually subsides, the eye becomes normal, and both eyes heal. A last resort would be injection of the germicide into the remaining eye, which has proved successful in my own experience.—*Am. Four. Ophthal.*, June, 1890.

Post (M. H.) on Removal of Piece of Steel from the Vitreous Body, with Recovery of Perfect Vision.—One hour and a half after the right eye had been struck by a piece of steel from a hammer that was being used, examination showed a clean cut through the lower lid near its centre, through a corresponding point of the sclera; the ophthalmoscope showed the shining piece of metal with several air bubbles in the upper part of the vitreous. The next day an operation was performed under antiseptic precautions and cocaine; the inner and upper quadrant of conjunctiva was dissected back; a meridional incision was made just at the inner border of the insertion of the superior rectus, a Graefe knife being used; the usual shaped electro-magnet was introduced and the foreign body attached itself immediately with a perceptible click, and was withdrawn. The piece of steel was four mm. long, two broad, and weighed about half a grain.—*Am. Four. Ophthal.*, May, 1890.

Magee (R. S.) on a Case of Intraocular Sarcoma Following Traumatism in Eleven Weeks.—A German laborer, while quarrying rock in January, 1890, near Lawrence, Kansas, was struck in the right eye, producing only moderate pain, which, however, increased; swelling and general inflammation set in. In two weeks the globe ruptured, matter discharged, pain about ceased, though tenderness continued. On examination the atrophy of the globe was marked with sympathetic irritation and dimness of vision of the fellow eye. After enucleation the globe of the injured eye showed, under microscopical examination, melano-sarcoma of choroid. No family history of cancer. Recovery has been complete, and so far no signs of returning growth.—*Kansas Med. Four.*, June, 1890.

Motais on the Hygiene of Vision.—Do scholastic studies dangerously affect vision? In Germany, Switzerland, and elsewhere this has without doubt been demonstrated from numerous researches. But these researches are still so rare in France that physicists yet pretend that scholar's myopia, so frequent in Germany, is only a question of race, and does not exist among us. To fix attention upon this point, we have examined about 5,000 scholars of colleges and schools in the west centre of France, a region that cannot be suspected of any affinity with the German race. We have arrived at the following conclusions: The general mean of myopes in the colleges for classes of rhetoric or philosophy is 35 per 100. If we leave out of this average the military Prytaneum at La Flèche, where, for special reasons, the proportion is not over 26 per 100, we arrive, in our lyceums and ordinary colleges, at the average of 46 per 100 in philosophy. Now, the average found by Cohn in Germany is 57 per 100, and by Emmert for Switzerland, 50 per 100. We are hence authorized in affirming that scholar's myopia exists here in nearly the same degree as in Germany. The student origin of myopia is made more evident by the following figures selected from our general average. In the lowest classes we found myopia 0; in the third, 17 per 100; in philosophy, 35 per 100. The progression is too pronounced to need any repetition. The influence of scholastic duties is modified by many factors, notably by heredity. A myopic father transmits generally a myopic predisposition to his daughter and the mother to her son. A quarter of the myopes we have seen presented no complications. In these cases myopia was a simple infirmity. Three quarters were affected, on the contrary, with complications often sufficiently severe to force a certain number of the young men to renounce the careers chosen by them, or to exercise them under conditions of deplorable inferiority. On the other hand, we know that the number of myopes, who decide their entrance into the army by the use of glasses, is steadily increasing. In the auxiliary service this procedure is not a drawback. But in the active service every myopic soldier or officer deprived of his glasses is absolutely disarmed. There is, therefore, a grave situation which it is important to remedy. We can in quite a large measure modify the bad hygienic conditions in the majority of

our colleges. Certain reforms, admitted by all hygienists, are more or less imposed by rules. We will enumerate them briefly. Diurnal lighting, unilateral or bilateral, so that the darker portions are yet sufficiently lighted (Javal). Nocturnal lighting, a jet of gas with glass to six students, while the electric light is the most hygienic artificial flame in every respect. Furniture for colleges: six kinds of tables in two places, four kinds for the primary schools; each of these forms adapted to the size of the scholars. Seats placed near the tables. Tables turned in such a way that the daylight comes laterally, and preferably on the left side. Writing right, body right, copybook right (Geo. Sand). Printing of the books for the classes with fresh type, enlarged in width, on yellowish paper (Javal). The following reforms are less widely recognized. We insist especially on the the last. Practical reforms, applicable without expense to old schools of instruction. They are: windows with large sashes; replacing ground glass with transparent; changing the direction of the tables towards a lateral daylight; increasing the means of artificial lighting; grouping the students intelligently around the lamps; tables and benches lowered by the use of the saw on the feet, or elevated by brackets; trimming the trees that project shadows over the windows, etc. *More frequent interruptions in the hours of study.* The use of this precaution, often theoretically advised, is shown by the two following facts. At the School of Arts and Trades at Angers, and the military Prytaneum at Flèche, myopia is relatively infrequent, in spite of very imperfect instructions at these establishments as to the hygiene of the vision. But at the School of Arts the studies are frequently interrupted by manual work. At the Prytaneum the studies, very wisely regulated by General Brault, never last longer than one hour and a quarter, and the recreations consist of very active exercise. Let us add that the average of the instruction at the Prytaneum is at least equal to that of the ordinary lyceums. The league for the propagation of physical exercises in the colleges should find here an argument of great value. *Inspections of vision in colleges and schools.* We regard these inspections as indispensable. (1) In the interest of colleges, and for reports on useful reforms and the general care of the hygiene of vision. (2) In the interest of students, because the oculist discovers in time quite a number of ocular lesions (asthenopia, strabismus, excessive hypermetropia, astigmatism, commencing myopia), which, most frequently, are noticed too late by the parents. He prescribes the treatment and decides the choice of glasses, without leaving it to the caprice of the student. To these measures taken in the colleges we would finally add the counsel of following the same hygiene in the families, where the conditions of work are very often defective. In a word, scholar's myopia exists in France as well as Germany already to an alarming degree, and it will increase if we content ourselves with advocating reforms without applying them.—*Rec. d'Ophtal.*, Paris, April, 1890.

REPORT ON DISEASES OF THE SKIN.

BY C. W. CUTLER, M.D.

Hutchings (M. B.) on the Use of Arsenic in Skin Diseases.—The author concludes his remarks on the use of arsenic in skin diseases as follows: Arsenic is useful, or even "almost specific," in a few diseases of the skin, as pemphigus, psoriasis, chronic eczema, sarcoma, lichen ruber, etc., but the prescribing of the remedy for every skin disease without regard for a diagnosis, and without consideration of the degree of irritation present is inexcusable empiricism. Even in cases where it might be indicated, the condition of the alimentary tract will often preclude its use, as digestive disorder might be increased and, in many cases, produce bad consequences reflexly upon the skin. Many indolent or subacute diseases of the skin may be benefited, but often this alone will be an insufficient indication, and time and drugs will be wasted in fruitless groping in the dark. Arsenic must as surely be accorded as definite a place in definite diseases of the skin as is given to any remedy in our pharmacopœia, in any disease met by the general practitioner. The use of the drug empirically in indiscriminate skin affections must come to share the odium which attaches to "doctoring the blood," after the charlatan and patent-medicine plan. —*Atlanta Med. and Surg. Jour.*, June, 1890.

Neumann on Hereditary Syphilis.—Prof. Neumann, basing his observations

on over 100 cases of hereditary syphilis, came to the following conclusions:

1. The syphilitic mother may in every stage of her disease, from infection before as well as after conception, transmit the disease to her offspring.

2. The mother affected after conception sometimes transmits syphilis to the fœtus.

3. If infected after conception, and if the father was syphilitic at the time of procreation, then the influence is much more intense. The children die *in utero* or are born syphilitic.

4. In post-conceptional syphilis, if the infection be unknown, then the relation is the same as in preconceptional. Syphilis acquired in the last months of pregnancy is rarely transmitted to the offspring.

5. If infection and conception be simultaneous, then half of the children die. Children may be born, however, when both parents at the time of conception are syphilitic.

6. Infection before conception depends upon the time when occurring. The further removed from the time of conception, the more favorable the prognosis for the offspring.

7. Those mothers who have acquired syphilis only in the last month of pregancy, while the father at the time of conception was healthy, offer the best prognosis for the children. The same holds good for tertiary syphilitic patients. The worst prognosis is in those cases where the time of conception and infection go hand in hand, or where the father at the time of conception suffers from recent syphilis.

8. Especially do those cases show the dangerousness of the paternal syphilis in which the father was syphilitic at the time of conception, the mother only becoming infected after conception, and the child soon after infection being born macerated. This contradicts Boeck and Onvere, who assert that the child of a syphilitic father is healthy.—In *Journal of Cut. and Genito-Urinary Diseases*, July, 1890. From *Deutsche Med. Wochenschrift*, March 7, 1889.

On Leukoplakia.—Leukoplakia has been described by various authors as ichthyosis linguæ, smokers' plaque, keratosis and psoriasis of the tongue. The disease attacks the tongue, inner surface of the lips and cheeks, and the hard and soft palate. It is exceedingly chronic in its course, and it is said to develop chiefly in smokers, particularly those who use cigarettes, or who habitually take highly seasoned food. It begins as a slight hyperæmia of the mucous membrane with scattered, large papillæ, slight depressions, and often deep fissures in the surface of the tongue. The mouth feels dry, there are often pains in the tongue, and the patient complains of the organ feeling stiff, and as though it were asleep. Gradually the mucous membrane becomes somewhat hard and thick, and single gray spots appear, but little raised above the level of the surrounding tissues. These spots after a while closely resemble a surface to which nitrate of silver has been recently applied. That they are not dependent upon syphilis is proven by the facts that they are not influenced by antisyphilitic treatment, and that cases are recorded where, during the course of leukoplakia, syphilis has been acquired and the secondaries have appeared. What makes leukoplakia of especial interest is the frequency with which it precedes cancer. Nedopils says that the cause of cancer as following leukoplakia is the constant irritation to which the diseased spot is subjected, just as cancer may at times appear at the seat of a long cauterized wart. Leukoplakia may last for years before it takes on malignant growth. Of a number of cases of epithelioma with a history of leukoplakia preceding the cancer development, Rothmann states that the average time elapsing between the appearance of the *plaque* and the development of malignancy was eighteen years.

The treatment of leukoplakia is, in its results, not satisfactory. The disease, though apparently a single hyperproduction of the epithelium with a moderate superficial round-celled infiltration of the subjacent tissues, is exceedingly resistant to the effect of remedial measures. Lately the application of compound tincture of benzoin has received high praise, and has recorded to its credit cases of cure. It should be applied many times a day to the affected areas, and acts more potently if preceded by a boric-acid mouth wash. Lunar caustic distinctly aggravates the affection, and should be abandoned as a remedial agent in these cases. Smoking, or the use of high seasoning, must, of course, be prohibited. If in spite of treatment the disease shows a decided tendency to spread, the Paquelin cautery should be fully applied to all involved areas. This has effected several cures, even when there

was reason to believe that malignancy had already developed. As a final means of treatment the surgeon will at times be compelled to resort to excision of a whole or a part of the tongue, as in the treatment of epithelioma.—Ed. in the *Univers. Med. Mag.*, May, 1890.

Bulkley (L. D.) on the Dangers of Syphilis in the Practice of Dentistry.—The poison of syphilis may be received from four different sources: 1st. From the initial sore or chancre; 2d. From mucous patches; 3d. From syphilitic ulceration; and 4th. From the blood.

The chancre, or initial sore of syphilis, is occasionally formed upon the lips, tongue, and other portions of the buccal cavity, but generally the lesion is so marked and painful that the patient avoids the dentist and there is relatively little danger of infection from this source. But infection does sometimes occur.

The second source of the contagion, namely mucous patches, is far more fruitful of infection, and that against which special care must be exercised. The secretion from them is sticky, and intensely contagious. It is from these lesions that fresh chancres are most commonly contracted, and it is this secretion which adhering to instruments and articles such as cups, spoons, pipes, etc., gives rise to syphilis in most unexpected manners.

The third and fourth sources of infection are the least likely to present dangers in the practice of dentistry, although it is quite possible for them to be a means of communicating syphilis. — *Med. News*, April 26, 1890.

Unna on the Internal Use of Ichthyol.—Unna says that ichthyol is most useful internally in affections of the peripheral blood-vessels. In numberless cases of seborrhœa of the head and seborrhœic eczema of the face occurring in females, there is a waxy complexion, very pale lips and conjunctivæ, migraine, backache connected frequently with scanty and painful menstruation, constipation, great want of appetite, palpitation, lassitude, and abnormal desire for sleep, which is followed on awaking by headache and a feeling of fatigue. Here ichthyol administered internally for a considerable period produces a marked effect, not only rendering the skin clear, but making quite another being of the patient. Again, in the acne rosacea of elderly men who eat and drink too freely, and which is frequently associated with bronchial catarrh and emphysema, ichthyol reduces the peripheral hyperæmia and the catarrh. Amongst general diseases perhaps that in which ichthyol is most capable of being of service may be said to be rheumatism, including all the various forms that go by that name, from muscular rheumatism to rheumatoid arthritis.—*Lancet*, March 8, 1890.

Couper on Eczema of the Nipples.—Eczema of the nipple, during the early days of nursing especially, is a very painful and intractable affection, leading to the formation of crusts and fissures. In such cases one part of iodoform dissolved in eight parts of ether and applied to the nipple with a camel's-hair brush, has proven a very satisfactory plan of treatment.

The nipple should be perfectly dry when the application is made and the iodoform wiped off thoroughly before the child is placed at the breast.—*Glasgow Med. Jour.*, June, 1890.

Couper (D.) on the General Treatment of All Forms of Acute Dermatitis.—The plan of treatment to be followed in all forms of acute dermatitis depends upon the following out of three indications—viz., cleanliness to the affected part, promotion of healthy action, and protection during the process of recovery.

The process by which cleanliness is secured fulfils at the same time the second of the above indications. The patient is placed in a bath of water, the temperature of which is about 90° F., and is gently rubbed over with soft soap (sapo-mollis). This loosens and removes the epidermal *débris*, and causes a free circulation of the blood in the capillaries, "and probably moves obstruction in the congested small vessels by flushing them with an increased current," in much the same way as gentle friction acts beneficially in mammitis. In many cases this is sufficient, especially if they are acute, or if the skin is delicate; the temperature of the bath is then reduced by a few degrees, the soap washed away, and the patient submitted to a tepid or cold-water shower bath, and carefully dried. The third indication is met by the application of an emollient, the favorite form of which, with Lassar, is—

Acid. salicylic.....	2 pts.
Pulv. amyli.....	
Pulv. zinci oxid.....	ää 24 "
Vaselin Flav.....	50 "

In chronic cases, or in more acute cases where the soap alone does not suffice, its action is supplemented by the free application of a tarry ointment and then the same treatment continued as when the soap was used.

The formula for the tarry application is as follows :

Creasoti	ʒ i.
Ol. cadeni	℥ i.
Ol. olivæ	℥ ii.

Syn.—Liq. picis. co.

The creasote is the active principle of heavy beech oil ; oil of cade is very similar to oleum rusci, the one being obtained from birch oil, the other from juniper.

Lassar was the first to recommend this plan of treatment.

Hebra's method of treating chronic eczema of the legs is in many respects just like Lassar's, the solvent action of the green soap being there taken full advantage of, and, as we all know, with good results. But the novelty of Lassar's method consists in the boldness with which these agents are employed, and the emancipation which he gives us from the fear of using water, that has prevailed amongst us since Hebra's time. — *Glasgow Med. Jour.*, June, 1890.

OCCASIONAL REPORT ON INSANITY AND DISEASES OF THE NERVOUS SYSTEM.

BY FREDERICK PETERSON, M.D.

Diller (Theodore) on Chorea in the Adult, as Seen among the Insane.— The author has collected from various asylums in the country thirty-nine cases of chorea in the adult, of which he makes an interesting and careful study. A direct hereditary transmission of the disease was noted in but three of the cases. The form of insanity in most of them was dementia. Four were imbeciles, two were maniacal, and one melancholiac. The following are the conclusions drawn by the author from his researches in this direction :

1. There is to be found among the insane in hospitals and asylums in this country 1 choreic among each 425 of population.

2. In all long-standing cases of chorea there is a more or less marked tendency to mental deterioration which, in many cases, progressively increases, and finally terminates in dementia.

3. Many cases, even when there exists a considerable degree of mental impairment associated with chorea, enjoy fair physical health, and apparently live almost as long as they would have done had they been free from the mental and nervous affections.

4. The proportion of male to female adults is in about the same ratio as is found to exist between the sexes in children affected with acute chorea.

5. The same causes that are known to produce chorea in children are found to operate in causing the disease in adults ; but in the case of the latter, additional causes peculiar to adult life, such as apoplexy, anxiety, etc., are capable of producing the disease.

Emotional causes may produce chorea when operating on a person already predisposed to the affection.

A person having a family history of insanity, chorea, or epilepsy, or indeed any nervous affection, is predisposed to an attack of chorea.

Persons popularly known as "nervous" are especially predisposed to an attack of chorea ; but when the disease is noted to exist in phlegmatic robust persons it is probably the result of rheumatism or coarse brain lesions.

6. Persons of adult years are sometimes, though rarely, attacked with chorea while suffering from rheumatism—the disease being of about the same character as that commonly observed in children, but more likely to become chronic.

7. As to the pathology, the following appear to be reasonable conclusions :

(*a*) A number of cases arise from, and are caused directly or remotely by, an attack of rheumatism.

(*b*) In the majority of cases heart disease is absent and there is a negative history as to rheumatism.

(*c*) Coarse lesions, acting as irritants to the motor cells of the brain or the tracts proceeding therefrom, are in some cases the prime cause. Such lesions most commonly are clots recent, organized, or broken down.

8. Chorea is to be found at all ages.

9. Persons may inherit the disease directly.

10. The disease may be congenital.

11. Chorea and epilepsy are intimately related to each other. Epileptic convul-

sion (Jacksonian) may be confined to a single member; the same is true of choreic convulsions.—*Am. Jour. Med. Science*, April, 1890.

Watson (Arthur E.) on Causalgia.—The disease known as causalgia was first described by Dr. Weir Mitchell. He employed the term in reference to a condition of neuralgia of the extremities, met with in patients who had suffered gunshot injuries during the late civil war. The pain is acute and burning, or neuralgic, and is often associated with a glossy state of the skin. The only treatment of any value is the constant application of cold water. Mr. Watson details a case of this kind which was observed in the Torbay Hospital, the history being as follows:

M. L——, aged forty-three, married; has had twelve children. No history of previous illness or of gout, syphilis, or rheumatism. On February 5th, directly after the patient had washed her hands, she was suddenly attacked with acute stabbing pain in the palms, but more marked in the right. The pain extended to the tips of the fingers, and she noticed soon after its commencement that they were of a white color, and shiny-looking, and that they were "drawn"—*i.e.*, flexed. There was also shooting pain down the forearms from the elbows, but this was not acute, like the palmar pain. The latter pain was so severe that the patient cried out, and could not bear the slightest pressure on the hands or fingers. Mr. Watson was called to see her at 8 P.M., and found her crying out with the pain. She described it as a cutting, burning pain, and most intense in the palms of the hands. The fingers were flexed on the palms, and the skin was white and shiny or glossy. The hands and fingers were distinctly warmer to the touch than other parts of the body. Temperature 98.6°. Heart normal. Bowels somewhat irregular. Tongue slightly furred and dry. A saline mixture was ordered, and the hands and wrists were wrapped up in a thick layer of cotton-wool.

February 6th.—The acute pain subsided suddenly at 2 A.M. On visiting her at 10 A.M. there was still some pain and tenderness. The fingers were flexed and of white and shiny appearance; she could not move them without pain. She remained two days without any further pain, but on the afternoon of February 8th she was seized with the same sudden pain in the palm of the left hand. The fingers were flexed, and she noticed that while the pain lasted they were white and shiny. During the intervals of the acute pain she felt a pricking sensation in the hands like "stinging nettles." The pain had disappeared in the right hand; there was no tenderness, and the fingers were of normal color and appearance.

She was seen again on the 14th, and stated that since the last visit the "stinging-nettle" sensation had continued. On the previous night the right hand was affected with the acute pain resembling that of the first and second attacks. She tried to relieve this by putting the hand in cold water, as she had been advised; but this did not diminish, and even seemed to aggravate, the pain. A few hours were allowed to intervene, and then the hand was put into very hot water, and this relieved the pain at once. (The water was so hot that she could not bear the left hand in it.) Although the acute pain disappeared on using hot water, a feeling of numbness remained in the hand during its immersion and for some time afterwards.

Two days after she had another attack in the right hand, which was relieved in the same manner. The patient was last seen on February 25th, and had then no pain. The fingers were of normal color and appearance. She would not use cold water for the hands, fearing she would bring on another attack.

Remarks by Mr. Watson.—The cases described by Weir Mitchell were relieved by moistening the hands or parts affected, and cold did more good than warmth. In this case drugs were useless, and of the several local remedies used, none gave the patient any relief except immersing the hand in very hot water. Cold certainly did more harm than good, and so convinced was the patient of this that she was afraid to use cold water. The pathology of the complaint is obscure, but I should be inclined to think it due to vaso-motor changes after the type of Raynaud's disease. The important points in the case are the following: 1. Acute, stabbing, burning pain in the palms of both hands, then left and right hands separately affected. 2. White and shiny appearance of fingers during attacks. Normal in intervals. 3. Cold increased the pain, very hot water diminished or arrested it. 4. The uselessnss of drugs, liniments, etc.—*Lancet*, March 22, 1890.

Roscioli (R.) on Cranio-Facial Asymmetry in the Insane.—Dr. R. Roscioli (*Il Manico*, 1889, v., p. 27), having in mind the earlier works of Lasègue, Amadei, Venturi, etc., on the importance of an asymmetric formation of the frontal bone and the facial cranium, examined most carefully 388 insane persons of the most various shapes, etc., and 100 sane persons. Entirely symmetric skulls he only found in about 30 per cent. of the insane and in 16 per cent. of the sane.

He does not ascribe any value to asymmetry of a slight degree, not even for the showing of a predisposition to insanity. The higher degrees of obliqueness of the skull are found in epileptics, but also in those suffering from other mental diseases, and in sane persons also; they, however, are to be regarded as a sign of degeneration, and are the more frequent the more distinct the group of diseases in question are to be regarded as a degenerative psychosis. Striking asymmetry would be able to essentially obscure the prognosis of a case of mania or melancholia progressing apparently favorably. Sommer, in his examination of skulls of the insane, has nearly always found cranial asymmetry present (*Virchow's Archiv*, Bd. 89 und 90); only 3.5 per cent. were symmetric. In agreement with Zuckerkandl, Meynert, Dohrn, and others, he thinks persistent asymmetry may not rarely be traced back to mechanical shifting of the cranial bones (intra-partum). 3.5 per cent. asymmetric skulls corresponded to the 3.6 per cent. breech-presentations, etc., while the first cranial position corresponds to a flattening of the left parietal and frontal region, and the second cranial position, *vice versa*, corresponding to the flattening of right parietal and frontal region in nearly the same frequency, usually 1 : 2.7 to 1 : 2.3. Those asymmetries dependent on presentations of the ends of the cranium will be the more pronounced the greater the misrelation between the internal pelvis and the volume of the head. A narrow pelvis in the mother, a striking difference between the length of the large father's and the small mother's head, will bring an influence to bear upon the child's head, which through these influences becomes relatively or absolutely too large, which cannot be otherwise than unfavorable. Especially is this the case in the crania of those children born of weakly parents, where orchitis, cerebral hypertrophy, etc., add to its size. (The crania of the insane are known to be more capacious than those of the sane.) Perhaps sometimes the so-called hereditary predisposition to insanity may be traced back to some such individual peculiarity, and indeed to some traumatic crushing and shifting of the brain during labor.—*Jour. Nerv. and Ment. Dis.*, April, 1890.

Peterson (Frederick) on a Case of Locomotor Ataxia with Complete Ophthalmoplegia and with Muscular Atrophies.—The case developed gradually the following symptoms of locomotor ataxia: lightning pains, ataxia, widely distributed anæsthesias of the lower extremities, loss of knee-jerks, and vesical and anal weakness. The history of the remarkable palsies of certain motor cranial nerves is best shown in a schematic representation of the nuclei of the affected nerves, thus:

Left.	Median Line.	Right.
	III.	
Sphinct. iridis. Paralyzed, 1884.	*Ciliary musc.* Paralyzed, 1890.	*Ciliary musc.* Paralyzed, 1890.	*Sphinct. iridis.* Paralyzed, 1884.
Levat. palp. Feeble, 1884. Paralyzed, 1885.	*Rect. int.* Feeble, 1882 to 1884. Normal, 1885. Paralyzed, 1890.	*Rect. int.* Paralyzed, 1884.	*Levat. palp.* Feeble, 1884. Paralyzed, 1885.
Rect. sup. Feeble, 1884. Normal, 1885. Paralyzed, 1890.	*Rect. inf.* Feeble, 1884. Normal, 1885. Paralyzed, 1890.	*Rect. inf.* Feeble, 1884. Paralyzed, 1890.	*Rect. sup.* Feeble, 1884. Paralyzed, 1890.
Obliq. inf. Feeble, 1884. Normal, 1885. Almost completely paralyzed, 1890.			*Obliq. inf.* Paralyzed, 1884.
	IV.		
Obliq. sup. Almost completely paralyzed, 1890.		*Obliq. sup.* Paralyzed, 1890.	
	V.		
Temp. Feeble, 1885. Feeble, 1890.	*Masseter.* Feeble, 1885. Feeble, 1890.	*Masseter.* Feeble, 1885. Feeble, 1890.	*Temp.* Feeble, 1885. Feeble, 1890.
Pteryg. ext. Feeble, 1890.	*Pteryg. int.* Feeble, 1890.	*Pteryg. int.* Feeble, 1890.	*Pteryg. ext.* Feeble, 1890.
	VI.		
Rect. ext. Normal, 1884. Normal, 1885. Paralyzed, 1890.		*Rect. ext.* Normal, 1884. Normal, 1885. Feeble, 1890.	

Besides these various lesions, which are undoubtedly nuclear, the patient presents great atrophy of some of the muscles of the limbs and trunk, for instance, of the right trapezius, right thenar eminence, right

sartorius, whereas the left hand is almost a *main en griffe*.

The patient had syphilis in 1875, and the ocular and tabetic symptoms began to be manifested in 1882.

The author pointed out certain similarities between the syndrome presented by this patient and polioencephalitis superior with poliomyelitis.—*Four. Nerv. and Ment. Dis.*, July, 1890.

THERAPEUTICS.

Conclusions of the Therapeutic Committee of the British Medical Association on Hypnotics.—

SUMMARY OF RESULTS.

The results are best summarized under the following headings:—1. Dose of drug given? 2. Whether sleep is produced with certainty, how soon it comes on, and how long it continues? 3. Are there any dangerous or other disagreeable effects produced? 4. Whether the drug loses its effect?

SULPHONAL.

1. *Dose.*—In thirty-two of the cases recorded, 20 grains were given in eleven instances, once at night. Sleep came on in half an hour to three hours; in one case in five hours, and in another in nine hours. A second dose on the succeeding night in one case produced sleep in five minutes. Sleep lasted in four cases all night; in four cases six hours; and in three cases one to two hours. With 25 grains (four cases) sleep came on in two hours and lasted six hours or all night. With 10 and 15 grains there was less sleep produced, and in a case of pneumonia (15 grains) there was no sleep after the drug. The few cases (seven in all) in which 30, 40, and 60 grains were given, showed that these doses did not possess greater hypnotic effect than a dose of 20 grains. In a case of chronic gout 30 grains had no effect.

Disagreeable After-Effects.—In six out of ten cases in which 20 grains had been given disagreeable after-effects were noted: drowsiness next day was noted six times; giddiness four times; and headache and inco-ordination of gait each twice. In four cases where 10 grains had been given, drowsiness was noted once; in five cases with 15 grains, drowsiness was noted twice and giddiness twice; with 25 grains (four cases), drowsiness was noticed twice, giddiness once, and headache once. In seven cases, with 30 to 60 grains, drowsiness was noted four times, giddiness twice, headache twice, inco-ordinations of gait and vomiting each once.

Whether the Drug Loses its Effect?—Several of the cases show that a second dose on the succeeding night has a greater effect than on the first night. Thus, in one case, 20 grains produced on the first night two hours' sleep with no bad after-effects; on the second, a similar dose produced eight hours' sleep, with drowsiness, giddiness, and inco-ordination of gait on the following day. In some cases prolonged use of the drug appears to diminish its effect. Thus, in one case (asthma and bronchitis) 20 grains was given every other night for eight weeks. During the first fortnight sleep came on in an hour and lasted twelve hours each night. The drug was then omitted for a week, when the insomnia returned. In the succeeding five weeks the drug, after three hours, produced six hours' sleep. In a case of phthisis 20 grains was given every other night for twenty-six days, except for five days, when the dose was reduced to 10 grains, but afterwards was increased. During the time the patient was taking 20 grains, after an hour, he slept for four to six hours. The drug was omitted for a fortnight, and, on recommencing it, it produced only drowsiness, and no sleep. In a case of neurasthenia and insomnia, quoted by Mr. Priestley, sulphonal, 10 to 20 grains, did not lose its effect during six months.

PARALDEHYDE.

Single doses of 40 to 60 minims (14 cases) produced sleep in five to fifteen minutes; in 2 cases in half an hour; in 1 case in an hour. In most cases the sleep was wakeful and restless, and lasted very varying times, in 1 case only three quarters of an hour, in another case there was restless dozing for three hours, in another sleep for two hours; in 10 cases sleep lasted from three to six hours, and in 1 case sleep for twelve hours. These results refer to single doses. Half a drachm every three hours produced within half an hour two hours' sleep; 20 minims every four hours for fourteen days produced better sleep at night, but not during the day.

Disagreeable After-Effects.—Giddiness and drowsiness were noted each once,

vomiting three times, and retching and nausea each once.

Tolerance of the Drug.—In a case of mitral stenosis on two nights 40 minims gave two to five hours' sleep; on the third night a similar dose had no effect; on the fourth night 1 drachm was satisfactory, but on the sixth night it produced no effect. When the paraldehyde failed it seemed to produce slight excitement. Morphine succeeded well afterwards.

Chloralamide.

In 1 case 20 grains, and in 6 cases 30 grains, were given in single doses. After the 20 grains, sleep came on in twenty minutes and lasted three hours, with half an hour's interval of waking; after 30 grains, sleep came on in fifteen minutes to half an hour (4 cases), one to two hours (2 cases). Sleep lasted all night in 3 cases, in two cases four to five hours, and in 1 case there was two hours' dozing, then an interval of wakefulness, and then two hours' sleep.

Disagreeable After-Effects.—None observed.

Tolerance of the Drug.—Thirteen consecutive observations were made in a case of pernicious anæmia, with several weeks' insomnia. Thirty grains of chloralamide failed once on the ninth night; on the other nights the drug produced, in one to two hours, restless sleep, lasting all night, with two or three short intervals of wakefulness.—*Brit. Med. Jour.*, July 26, 1890.

Chapin (W. B.) on Chloralamide. The cases in which I have used chloralamide have been mostly those of insomnia of a very persistent character, in some of which all other hypnotics had failed. Although my experience with the drug had been confined mostly to one class of cases—those of insomnia depending on some nervous affection—I have seen enough of its action to convince me that not only does it fail to possess all the virtues attributed to it, but, owing to its uncertain action and the many unpleasant symptoms which it produces, it is inferior to most of the other new hypnotics.

It is maintained that chloralamide has no effect on the respiration or circulation, and can be given in cardiac cases almost with impunity. In doses under three grammes I believe chloralamide to be harmless; but when given in larger doses it will produce effects on the circulatory and respiratory systems that are ominous of what may happen if it is not used with caution. In one instance, two hours after having administered a dose of three grammes to a robust patient, I was sent for by the family, as the patient was "acting queerly." I found her sleeping very heavily, could be aroused with difficulty, respirations labored and 124, and with a pulse of 105. In larger doses I have seen much more pronounced effects, and I would certainly be very cautious in giving this drug in cardiac cases.

Its action as a hypnotic is very uncertain, taking effect in some cases in a very few minutes, while in others its action is delayed for several hours, or else has no effect at all. Sulphonal, to which it is claimed to be superior, is uncertain in its action, but can usually be relied on in certain cases, while chloralamide cannot be depended upon to act twice alike on the same patient. In one patient it produced no effect except headache, nausea, and vomiting, and great restlessness for eight hours, when the patient fell into a heavy sleep which lasted for twelve hours. On the following day at 5 P.M., I gave the patient, under like conditions, the same dose as on the preceding day; in half an hour she was asleep, and slept for only two hours. Repeated doses had no effect, but a moderate dose of chloral was successful. In some cases it appears to be accumulative, especially if given in its undissolved form, and I have known a second dose to have such a depressing effect on the heart as to render stimulants necessary. If four grammes fail to produce sleep, it is useless to repeat the dose.

Although in some cases it causes a refreshing sleep, with no unpleasant after-effects, yet just as often does it cause headache, which is sometimes very distressing, nausea, great restlessness, or depression. I find these unpleasant symptoms almost invariably occur when its administration fails to produce sleep. A feeling of exhilaration lasting for an hour or two often occurs after taking this drug. A patient told me it always made her feel as though she had taken a pint of champagne; afterward she would become restless, then depressed, but it would never make her sleep.

In other hands chloralamide may prove all that is claimed for it, but after giving it a fair trial I have ceased to use it in my practice.—*N. Y. Med. Jour.*, Aug. 9, 1890.

Christie (D.) on Cocaine as a Local Anæsthetic.—An adult suffered from epithelioma of the penis. Chloroform was carefully administered, but, after a few inhalations, proving a bad subject for a general anæsthetic, it was decided to try cocaine. Twenty minims of a five-per-cent. solution of the hydrochlorate were injected, in five-minim doses at short intervals round the seat of incision and into the urethra. A quarter of an hour after first injection, amputation was performed without the patient experiencing the *slightest pain;* indeed, he would not believe me when informed that the operation was over.

Another point of interest is that, except from the large blood-vessels, there was hardly any hemorrhage, doubtless due to the constricting effect of the drug on the capillaries. As to the after-treatment, there is nothing worthy of note, only that the anæsthesia produced lasted over a day, indeed the patient complained of no pain after the operation. He recovered without a bad symptom, and now enjoys excellent health.—*China Med. Missionary Jour.*, June, 1890.

Carney (J. H.) on the Vomiting of Pregnancy Treated with Cocaine.—The patient, the mother of four children, consulted me a few weeks ago for severe vomiting, which troubled her for ten days. She stated she was pregnant at the third month, and previous to the last fortnight had enjoyed good health. Vomiting troubled her during the early months of her previous pregnancies, but was not so severe. She was weak, and presented an emaciated appearance; face flushed, pulse 120; abdomen tympanitic, and painful on pressure; tongue thickly coated; temperature 103°; bowels confined for three days, unable to retain the smallest quantity of any kind of nourishment; vomiting was intensified by movement, syncope following each evacuation.

The uterus was markedly anteflexed; the cervix was much swollen, and the surface, especially about the os, eroded, and bled freely when touched; the erosion extended into the cervical canal. The whole of the vaginal wall, the cervix, and cervical canal, to the extent of about one inch, were painted with a saturated solution of cocaine, and a suppository containing a grain of cocaine and a quarter of a grain of morphia was placed against the os uteri. The bowels were relieved by enema, after which the temperature fell to normal, and the tongue cleaned. Patient did not vomit for eight hours after cocaine was applied; at the expiration of that period vomiting re-commenced, but was less severe. The application of cocaine was repeated, after which she made an uninterrupted recovery.—*Australian Med. Jour.*, June 15, 1890.

Unusual Effect of Morphine Injections.—A patient has been taking hypodermic injections of morphine for some considerable time. I have found that it occasionally (although rarely) happens that he is seized with the following symptoms after an injection: Sudden tingling ssnsations in the fingers, feet, and top of scalp, followed quickly by marked determination of blood to the head (producing flushing of face, swelling of the blood-vessels of head and face), and violent palpitation of the heart. These symptoms subside in a few minutes, but while they last produce feelings of great anxiety and uneasiness. The following points I have also noticed: 1. That while these attacks are very infrequent, there is no guide to their occurrence, as they are not due to any increase in the amount of the drug taken either during the day (the amount taken having remained about a constant average for months) or at the particular dose. Indeed, I have known these symptoms to follow a smaller injection than usual. 2. The attack follows so suddenly upon the injection that I cannot think that absorption can have taken place into the system. 3. It is not due to the injection being made in any unusual place or to a different solution of morphine than usual having been used.[1]

In *Brit. Med. Jour.*, July 26, 1890, Mr. Robert Hagyard explains this unusual effect as follows:

"I beg to state that I have frequently noticed the symptoms he names, and I find that it is due to the solution being directly injected into a vein, and if the querist will try injecting into one of the superficial veins he can readily produce the symptoms, which quickly pass off, but which at the time cause great alarm to the patient."

Wood (H. C.) on Anæsthesia.—The author sums up the treatment of accidents of anæsthesia as follows:

Avoid the use of all drugs except digitalis and ammonia.

[1] Anonymous correspondent *Brit. Med. Jour.*, July 19, 1890.

Give the tincture of digitalis hypodermically.

Draw out the tongue, and raise up the angle of the jaw, and see that the respiration is not mechanically impeded.

Invert the patient briefly and temporarily.

Use forced artificial respiration promptly, and in protracted cases employ external warmth and stimulation of the surface by the dry electric brush, etc., and, above all, remember that some at least, and probably many of the deaths which have been set down as due to chloroform and ether, have been produced by the alcohol which was given for the relief of the patient.—*Med. News*, Aug. 9, 1890.

Injections of Ether for Neuralgia.—Dr. Kums, of Antwerp, has conceived the plan of using subcutaneous injections of ether in the treatment of neuralgia. For the most part, the patients on whom this method was practised were subjects of rheumatism. The quantity of ether employed for each injection is a cubic centimetre, in other words, the amount which an ordinary Pravaz syringe will hold. The author prefers to use Hoffmann's anodyne, containing equal parts of ether and alcohol. The injection should be made as near the seat of pain as possible. Some smarting ensues as the injection is made, but this soon passes off. The injections have been used by the author in various cases of sciatica, cervico-brachial neuralgia, cranial and facial neuralgia, and many other neuralgic conditions. Often a single injection has sufficed. In a certain number of instances, two or three have been found necessary.—*Med. Press*, July 30, 1890.

Sawyer (J.) on Ether as a Menstruum in Medication by the Skin.—The author says there are three separate obstacles to the absorption of a medicine through the skin, viz., the epidermis, the sebaceous secretion of the skin, and the relative insolubility of the drug. Knowing the power of ether in dissolving fatty substances, the author advises the employment of certain ethereal tinctures, with the idea that the ethereal solution will remove the sebaceous secretions, or at any rate more readily penetrate pores containing such secretions.

The drugs he most employs in this way are belladonna, iodine, menthol, and capsicum.—*Lancet*, July 12, 1890.

James (R. B.) on the Value of Atropia in Enuresis. — The author's cases number fifteen. In only one case did any symptoms of poisoning occur, and in this not sufficient to warrant a suspension of the remedy, or even a diminution of the dose. Under the long-continued use of the drug, though in such large doses, there were observed no bad effects from it; but, on the contrary, the children, being relieved from the stigma of being a "bed wetter," were brighter and less constrained than when the drug was left off, with the consequent return of the enuresis. It may be well here to state that some of these children, though under the age of five years, were so ashamed of their affliction that, on finding they had wet their beds at night, would exchange their wet sheets for dry ones from the cots of their slumbering neighbors, thus shifting the coming lecture to innocent shoulders; so great was the effect of the so-called "moral treatment."

Every case was absolutely controlled so long as the treatment was kept up, except in one case, where it lost its effects after some months of complete relief, and this, for some unknown cause, which was never overcome, though the drug was pushed to a dangerous point.

It is a matter of no little regret that, after such a promising beginning, the final result shows such a little gained.

On October 1st, after eight months of treatment of the fifteen cases, two cases were cured, and these mild cases; two others benefited, in that they did not wet their bed so often; one it ceased to benefit, while ten showed little or no improvement when the drug was stopped.

I stated that in some of these cases the dose could be diminished after the controlling dose had been continued for some time. Now, any long use of this diminished dose would lead to a relapse, and it is more than probable that the length of time before this relapse occurred was but little, if any, greater than it would have been had the drug been withheld entirely; and I am compelled to acknowledge that any thing short of the full controlling dose is of little value, though since the effect of the full dose lasts so long after the drug is stopped, one would suppose that smaller doses would serve to keep up this effect. Such was the principle upon which I worked, but without any great success.

In these cases there could be made out no cause for the trouble. They were all in good health otherwise; their food and hygienic surroundings were all that could be desired. They were allowed no fluid at night, but under the atropia treatment this point was not insisted upon, as it seemed to make no difference whether they had a moderate amount of fluid at supper or not. In short, these cases represented what we often find in private practice. Children in seemingly perfect health and under good moral training yet persist in wetting themselves and their beds without any assignable cause.

Now, since the long-continued use of atropia has no ill effect nor tolerance established that requires an increased dose, and since undoubtedly the vast majority of these cases can be controlled by the drug, we claim for these children and their mothers a valuable friend in atropia. When a child is too large to wear diapers, or they cease to be effectual, we can with confidence offer a substitute in the shape of a full dose of atropia, to be repeated every night until the child has outgrown his infirmity, and this point can be tested by having the drug withdrawn from time to time.

It will be well to add, in conclusion, that many other cases of enuresis were put on atropia, and it controlled them in every case under twelve years of age; and at this writing, April, 1890, thirteen months after the treatment was begun, these children are about as they were last October, receiving their nightly doses of atropia, and improved only as we have a right to expect with the advance in years. As to those over twelve years old who received this treatment, which was quite a number, can only say they did badly—cannot recall a case that was benefited in the least; and I fear that children over this age suffering from enuresis are subjects of such inherent defects that other drugs or means than atropia must be sought ere they are relieved.—*Jour. Am. Med. Assn.*, July 26, 1890.

Huzza (T. H.) on Tr. Carduus Marianus in Hæmatura.—A married man of sixty dreamed one night in July, 1889, that he was having intercourse with a young girl, awoke, and when he urinated passed blood. From that time on it was constant. He passed nearly four pints of urine in twenty-four hours, and fully one third of it was blood.

I saw him first about December 10, 1889. No pain was ever connected with the bloody urine. Was bloodier after exertion and less so Sunday afternoon when he was resting quietly at home. Some pain in back occasionally. Works every day and is on feet great deal. Lived four years in a malarial region some years ago. Has always enjoyed splendid health—does now, considering age. Microscope shows blood corpuscles in abundance.

After careful consideration a diagnosis was made of varicosity of the bladder. He was given phosphate of sodium ʒ ii night and morning in glass hot water; a pill containing leptandrin iridin, and euonymin; ext. ergot, 8 to 10 grs. a day in capsules. In a week he felt better, bowels moving freely, and able to work more, but urine same as ever. Odered to take tr. carduus marianus in one half teaspoonful doses three times a day. By mistake he took a full teaspoonful.

In two weeks the urine was the color of pale claret. In four weeks there was only a faint pink tinge. In two months no blood at all except after violent exertion or straining. Tr. carduus marianus cured him of hæmaturia of six months' standing and in four months there has been no return.—*Dixie Doctor*, June, 1890.

Bressler (F. C.) on Toxic Effects Following the Application of Emplastrum Cantharidis.—A man of thirty-three was ordered by another practitioner fly blisters, equal in area to forty-eight square inches, to be applied about a knee joint, the seat of a chronic synovitis. They were to be kept on fourteen hours. He was seen by the author eleven hours after their application, and was then suffering intensely from strangury. Frequent, painful, scanty micturition was the first symptom. The urine became bloody and later pure blood was passed. Nausea and vomiting supervened. The pain, at first confined to the vesical region, soon spread over the entire abdomen and into the back. There was moderate priapism and intense thirst.

Morphine was freely administered with plenty of water, and half-ounce doses of liq. ammon. acet. The vesicated surface was carefully cleansed by soap and water and absolute alcohol. Slight improvement followed in a few hours, but it was something like a forty-eight hours before convalescence was well established.—*Therapeutic Gaz.*, June 15, 1890.

Brine as a Preservative. — The papers published a short time ago an account of the discovery of numerous bodies of Hungarians who perished years ago in an insurrection. The bodies, nineteen in number, were discovered in a brine pit at Vizakna in Hungary. The Royal Gerichtsarzt, Dr. Heinrich König, of Hermannstadt, published more recently an interesting account of the autopsy made by him on the bodies thus found. The obduction made by him on July 6th was, he says in his report, of extreme interest, and the conditions presented were of importance in many respects as regards medical science. In external appearance, the whole of the bodies resembled those preserved in the museums in spirit. No trace of decomposition could be detected, the skin was of a grayish white color, the muscular tissue was rose-red, and felt like fresh flesh. All the intestines and organs, the lungs, heart liver, spleen, kidneys, bladder, stomach, and intestines, were scarcely more consistent than in fresh bodies; the brain was hard and dirty gray as in spirit preparations. The structure of the organs was plainly recognizable to the naked eye, so that they might have served for anatomical teaching. A remarkable fact, as Dr. König remarks, after having been preserved for more than 41 years! The colon contained copious yellowish-brown fæces, but without odor, and in the bladder yellow urine was present. Crystallized salt was found in considerable quantity in the interior of the bodies, which had been deposited, and settled in the various tissues and organs. It was met with even on the inner surface of the uninjured pericardium to the extent of five grammes. This shows in the clearest manner, as the author remarks, that substances dissolved in water can pass through skin and muscle, and it also explains how the beneficial action of mineral baths on the internal organs takes place. — *Med. Press.*, July 30, 1890.

Adams (J. H.) on Strophanthus in Heart Disease.—The author's report contains the details of eight cases of heart disease of different varieties. The author says that there is not at his dispensary a record of a case which persevered in the treatment in which strophanthus did not work some improvement. Of course, comparative relief from the symptoms is largely all the result that can be expected in these cases. There are so many factors at work for good or evil in heart cases that often the effects of medicine are not seen. Even with this point in view, in the few instances where complaint was made that strophanthus was doing no good or producing ill effects, it was determined that rarely any actual deterioration existed, and when it did, it was due to some outside influence. Combining the drug with nux vomica, and giving small doses every three hours, was found to produce the happiest results, not hesitating, in bad cases, to increase the dose until amelioration of symptoms was apparent. In cases of heart trouble of long standing which have been on constant doses of digitalis, strophanthus seems to act in a peculiarly happy manner.—*Univers. Med. Mag.*, Aug., 1890.

Harris (C. H.) on Whiskey vs. Typhoid Fever. — According to the author, "when a case of typhoid fever happens in a family, the physician and every member of the household, including the nurses and the child at the breast, should take three times a day a dose of good whiskey; for an adult two teaspoonfuls; for children, doses proportionate to their ages." The great difficulty, according to the author, seems to be the ability to procure good whiskey, so he advises the following formula:

℞ Anthemis,
Crushed or rolled oats,
Strawberry leaves . . . āā ℥ i.
White sugar . . . . . ℥ iv.
Co. spts. lavender . . . . ℥ iv.
Good 95 % alcohol,
Rain water . . . . . āā O iv.

Mix and macerate for 14 days, then strain through absorbent cotton.—*Dixie Doctor*, July, 1890.

Jenkins (J. H.) on Transfusion of Lamb's Blood in Typhoid Fever.—An adult male in the third week of typhoid fever had had seven hemorrhages, the last of which amounted to over a gallon—total loss of blood was nearly two gallons.

The patient was sinking very rapidly. Pulse was almost imperceptible and respiration labored. The capillaries of the conjunctiva had become congested and nervous phenomena were most severe. In fact, there was every evidence that death had come to this poor sufferer's relief.

Immediately upon the arrival of Dr. Wilson the operation was done, using the blood of a lamb, introducing about one quart of arterial blood. Immediate im-

provement was noticed. Pulse became stronger, respiration freer and easier, nervous system became quiet and the patient went off into a quiet and refreshing sleep—the best sleep he had taken since he took his bed. Convalescence has been rapid, and he is now able to sit up and walk across the floor a little—only thirteen days since the tra nsfusion.

The blood was introduced directly from the common carotid artery of the lamb into the patient's brachial vein at the bend of the elbow.—*North Carolina Med. Jour.*, July, 1890.

Heer on Saline Rectal Injections.—Dr. Heer, of Lausanne, endorses the recommendation already made by some other practitioners of rectal injections of tepid saline solution as an excellent substitute for intravenous transfusion in cases of acute anæmia from *post-partum* hemorrhage. The fluid injected is absorbed by the intestinal mucous membrane very rapidly. While as efficacious as transfusion, the procedure has the advantage of extreme simplicity, besides being absolutely safe and rapid in the execution. No trained assistants, and no apparatus beyond an ordinary enema instrument, are required. Dr. Heer relates a case in which the patient's life was saved by the plan described. Two enemata were given, each of 2 litres of 0.5 per-cent. solution of chloride of sodium (that is, a dessertspoonful of salt to 1 litre of tepid water).—*Brit. Med. Jour.*, July 12, 1890.

The Effect of Oil and Other Substances on the Secretion of Bile.—Dr. Rosenberg, by means of establishing biliary fistulæ in healthy dogs, has been able to extend somewhat our knowledge of the effects of different foods and drugs on the secretion of bile. It was found that towards the end of the three months during which the experiments continued, the quantity of bile diminished, but its consistency increased, probably through a deficiency of water. When the animals were kept without food, it was found that the flow of bile increased and decreased at the same periods of the day that it did when they were fed in the ordinary way. During the first hour of digestion the quantity increased, attaining its maximum during the second hour, after which it rapidly decreased, the consistence increasing as the quantity decreased. When fatty or oily substances were ingested, a stimulating action on the secretion was produced, a larger quantity of bile being secreted than when albuminoids or carbohydrates were taken, even large quantities of these substances producing far less bile than much smaller quantities of oil and fat. Indeed, these latter bodies possess a higher power of stimulating the secretion of bile than any other food or drugs, with the single exception of ox-gall, which, when taken by the mouth, increases both the quantity and the consistence of the bile excreted. Salicylate of soda increases the quantity but diminishes the consistence of the bile. The action of Durand's remedy—turpentine and ether—was found to be entirely due to the turpentine, which has a high stimulating power for the bile-secreting function of the liver. Carlsbad salts were tried, both in gelatine capsules and in solution; their effect was to decrease the quantity and to increase the consistence.—*Lancet*, July 26, 1890.

Booker (W. D.) on Stomach Washing in Children.—Stomach washing has not been employed a sufficient length of time, nor by a sufficient number of physicians, to justify a proper estimate of its value. As a rule, those who have used it most are more impressed with its value, while others who have tried it in but few cases, or not at all, can only see in it an unnecessary trouble or even a positive injury.

My experience with stomach washing in children is based upon its use in 150 cases of gastro-intestinal disturbance at the Thomas Wilson Sanitarium during the past summer, and 40–50 cases at this dispensary since that time. From the result of this experience I believe that stomach washing is of undoubted advantage in the treatment of the digestive disorders of infants.

It proved the quickest and most effective means for the relief of vomiting. In the great majority of cases vomiting was promptly relieved after the first washing, and in only one case was it found necessary to stop milk food before vomiting was checked. Vomiting occurring in serious dysentery was affected to a less extent by stomach washing, but in these cases benefit sometimes followed its use.

In summer diarrhœa there is more or less gastric disturbance, especially retarded digestion, even when there is no vomiting, and milk curds accumulate from a number of feedings, so that the stomach is seldom if ever empty. The removal of these curds not only prevents their passage into the in-

testine as a source of irritation and fermentation, but gives the stomach an opportunity to rest, and relieves the restlessness and depression so often dependent upon the presence of milk curds in the stomach.

The number of stools gradually diminished in most cases; and in acute cases, or in those of short duration, stomach washing generally afforded complete relief without any other treatment than attention to diet and cleanliness. In many cases, however, stomach washing was disappointing. In these, improvement often followed the first washing, and afterwards gave no further benefit.

Constipation dependent upon a catarrhal condition of the gastro-intestinal tract may sometimes be entirely relieved by stomach washing. A child eleven weeks old was brought to the dispensary last fall. It was feeble, thin, fretful, and had not grown at all since the second week, and seldom had a natural stool. Generally it had long spells of constipation alternating with attacks of diarrhœa.

Stomach washing was practised daily for two weeks, when the bowels were moved regularly once or twice daily; fretfulness had disappeared, and the child was stronger and commenced to grow.

Stomach washing is also of great advantage in cases of acute poisoning. A good illustration of this occurred in the dispensary during the past winter. A child about three years old was brought to the dispensary within a few moments after swallowing an unknown quantity of carbolic acid, in a state of unconsciousness and collapse. The stomach was thoroughly washed out by Dr. Finney, and almost as soon as the operation was completed the child became conscious, the radial pulse appeared, and a good recovery followed.

Stomach washing is contra-indicated in children affected with heart disease, serious bronchitis, and pulmonary trouble. When the tube continues to excite vomiting and strong resistance, it is doubtful if advantage follows its use. A feeble condition of the infant does not necessarily contra-indicate stomach washing, but often the opposite.—*Johns Hopkins Hospital Bulletin*, July, 1890.

Workman (R.) on Euphorbia Pilulifera.—I have notes of twenty-seven cases in which the drug was given. In thirteen cases of hay asthma, prompt relief was obtained in nine. The sneezing and discharge were diminished or stopped, and the congested sensation relieved. In one of the other cases partial relief was obtained, and in the remaining three cases the results were negative.

The fluid extract was administered in doses of thirty to sixty minims every four hours. In nearly all the above cases iodide of potassium and arsenic had been previously used.

In nine cases of coryza good results were obtained in six, the sneezing and rhinal flow ceasing or diminishing within thirty-six hours after the administration of the drug was begun. The doses were repeated every three or four hours.

In five cases of asthma, of frequent recurrence and long standing, marked relief was experienced in one case, the dyspnœa soon disappeared, and the attacks were always shortened. In the other four cases no good effects were obtained.

I have given it in a number of cases besides the above, and mainly with good results, though I have no notes of them. I have not tried it in cases of bronchitis, but think from its action that it would be applicable. It has a sedative effect on the mucous membranes of the nose and throat, and in many cases diminishes the discharge of mucus from these surfaces.—*Therap. Gaz.*, July 15, 1890.

Presence of Mercury in a Tape-Worm Coming from a Syphilitic Patient under Mercurial Treatment.[1]—A butcher boy, treated at Brême and at Gottingen by mercurial inunctions, having passed two scolices per anum, was treated with male fern, which caused the evacuation of two tænias (mediocanellatà), whose gray coloration caused the presence of mercury to be suspected. Chemical analysis having demonstrated that such was really the case, microscopical examination gave the following result: Treated with glycerine, each proglottis showed the metallic deposit in the vas deferens, in some of the vasa efferentia, and in the vesiculæ seminales. It was so pronounced in the oviduct that even to the naked eye it presented the appearance of a dark streak. The vagina looked like a dark tube, although on section the narrowed calibre was still found to exist. The walls of the uterus also contained a certain

[1] *Le Moniteur du Praticien*, March, 1890; *Lyon Médical*, June 8th.

quantity, while the ovary itself was quite free. After staining by means of eosine and other coloring matters, longitudinal and transverse sections revealed the fact that the entire parenchyma of the tænia contained particles of mercury, equally distributed. On the integument these were collected principally in the grooves or depressions, which was particularly the case in the neighborhood of the suckers; to the naked eye the head of the worm seemed blackish. Previous observations had already drawn attention to the dark color of the head in certain tape-worms, but this was due to a granular pigment deposited in the cellular tissue, and bearing no resemblance to the mercurial deposit mentioned above as being present in the external tegument of the head of the tænia. In the same way it cannot be mistaken for the collections of pigment, which Leuckart has noticed in the vagina, since he has himself stated that these collections were found only in old proglottides, while those found in the Gottingen case were situated in young and living proglottides. The remarkable part of this observation is the enormous amount of mercury absorbed by these parasites without having any appreciable influence on their vitality; with the exception of the gray coloration, microscopical examination did not reveal any difference from the parasites found in healthy animals.—*Canad. Practitioner*, Aug. 1, 1890.

Morehouse (O. E.) on Antifebrin Rash.—The first case was one of pneumonia in a man of forty-five years of age. Two 8-grain powders of antifebrin were prescribed, the second one to be taken four hours after the first. Profuse perspiration with lowering of the temperature to the extent of two degrees followed the administration of the first powder, but half an hour after the powder had been taken a slight erythematous rash appeared upon the face and chest. In four hours two-thirds of the other powder was taken, and was followed by profuse perspiration and another lowering of the temperature, this time to 100°. The rash, which had begun to fade before the administration of the last powder, now returned with greater intensity, extending over the whole body and being distinctly erythematous, with urticarious patches interspersed over the face and forearms. The rash remained out for six days and was intensely itchy.

The second case was that of a girl, aged nineteen, who had typhoid-fever, and whose temperature was 104.8°. Six grains of antifebrin were given. Profuse perspiration. The temperature was reduced to 103°, but a distinctly urticarious rash appeared upon the chest and forehead within half an hour, and remained visible for two hours. In four hours from time of first dose five grains were given. The rash immediately returned, with the perspiration, but with greater intensity. Temperature reduced to 101°. The rash was distinctly of an urticarious nature, and in wheals, extending more particularly over chest, face, and forearms; also on chest and forehead there was a slight rash resembling measles, but this latter soon disappeared, the urticaria remaining out for five days, then gradually fading away. There was intense itchiness.—*Montreal Med. Jour.*, July, 1890.

Davis (T. A.) on Some Poisonous Effects of Exalgine.—Mrs. W., aged forty-three, and approaching menopause, was suffering from cervical neuralgia. Her previous health was good, and physical examination revealed no organic disease. The patient was not of nervous habit generally, though she had been somewhat apprehensive at times during the recent menstrual irregularities accompanying the "change." *Present illness:* Complained of shooting pains from side of neck over shoulder, arm, and forearm, and between the paroxysms of pain, a lameness of the arm. She had not slept for three days and nights, though the pain had not been constant nor very severe. After having given a pill of arsenic, strychnia, cannabis indica, aconite, and cinchona, for a few days, without ameliorating her suffering, I prescribed two 7-grain powders of exalgine, to be given four hours apart, if the second powder was necessary.

Two hours after the first powder was given, I was called back, to find patient extensively cyanotic, with rapid, soft pulse (120), shallow, labored breathing, and skin cold and moist. Patient said that she felt a peculiar numbness, "a dead feeling all over," and a slight sensation of suffocation. Stimulants (brandy and coffee *per orem*), heat and friction to the extremities, improved her condition in a few minutes, and I left her in about a hour, with but a slight condition of cyanosis remaining. The effect of the exalgine was not special upon

the neuralgia, the patient said, but that the pain was lessened in proportion to the degree of general numbness. The skin presented a violet-blue color, which was diffused throughout the skin of the face and neck, forearm, fingers, and toes. The pill containing cannabis indica had not been taken for twelve hours before the exalgine was given. Recovery was complete in two weeks, after the salicylate of quinine in 2-grain doses, t. i. d., had been given.—*N. Am. Pract.*, Aug., 1890.

Semple (H. F.) on Exalgine Poisoning.—An hysterical woman of forty had suffered from nervous headaches for ten years. Latterly I have been administering exalgine, commencing with two grains twice a day, which gave great relief. The attack, however, recurred the next month, and two grains every four hours had very little effect, so I increased the dose to five grains twice a day. The first dose was taken at 10 P.M. after supper with great relief to the pain, and the patient slept till 6 A.M., when she awoke and felt headache coming on again, so took another dose and lay down. In about a quarter of an hour she jumped up with a sudden start and scream, and thought she was dying; she had such curious sensations, felt numb all over, fingers and toes tingled and felt dead; eyelids twitched continuously; the whole head felt as if it was swelled, and kept expanding and contracting alternately. There was great oppression in the region of the diaphragm. In a few minutes the patient vomited and ejected the remains of the medicine. She then felt much relieved and lay down and slept, after taking a little tea. Two hours after the patient got up, but felt ill; the headache was slighter, but not gone; the numbness of the fingers and toes remained nearly all day, but beyond this the patient was little the worse for her experience. She went out next day, but says she will be afraid to try the medicine again. I think that this so-called poisoning with exalgine is due to its being taken on an empty stomach, as the former dose was well borne when food was present, so I always order it to be taken after a meal. I give the drug dissolved in tinctura aurantii and diluted. I have found it useful in toothache, facial neuralgia, and in a case of long-standing lumbago. No beneficial effect of the drug have I found from less than two grains for an adult.—*Brit. Med. Four.* July 12, 1890.

MEDICINE AND PATHOLOGY.

Isham (A. B.) on the Influence of Typhoid Fever upon Venereal Diseases.—Case I.—F. C., æt. nineteen, was taken down with typhoid fever, August 11, 1876, having passed through the prodromic stages of headache, epistaxis, malaise, and hebitude. The typhoid symptoms were all well defined: abnormal temperature—highest in the evening, lowest in the morning,—abdominal tenderness, gurgling in iliac fossæ, rose-colored spots over the abdomen and chest, torpor, muttering delirium and frequent ochre-colored stools, with hemorrhages towards the end of the third week. On the first visit, attention being called to the penis, the prepuce was found œdematous, the walls of the urethra inflamed, while there was a copious discharge of a yellowish purulent fluid from the meatus. The patient acknowledged gonorrhœal infection. No treatment other than cloths wrung out of cold water, wrapped around the penis, was ordered for the gonorrhœa. It had entirely subsided long before the patient was convalescent from his fever, and no trouble was ever after experienced from it. The treatment for the typhoid was mainly expectant, but carbolic acid and iodine tincture, one-half drop of the former and ten drops of the latter, were given every three hours to act as a germicide, disinfect the discharges, and render the intestinal canal aseptic.

Case II.—C. B., æt. twenty-two, exhibited pronounced typhoid indications September 14, 1882, with a gonorrhœal inflammation and discharge in full blast. No treatment for gonorrhœa other than cold, wet applications to penis; carbolic acid and iodine tincture for typhoid. Gonorrhœa disappeared before convalescence from typhoid fever, and never reappeared.

Case III.—G. D., æt. twenty-five years, found prostrated with typhoid fever, gonorrhœa co-existing, July 23, 1885. Treatment the same as in cases one and two, with like result.

Case IV.—H. G., æt. twenty years; laid up with typhoid fever and also gonorrhœa, December 12, 1889. Typhoid fever treated with naphthol, but no other change from procedures in the other cases and result the same.

Case V.—A. J. S., æt. thirty-one years;

had passed through all stages of syphilis—chancres, syphilides, mucous patches, sore throat, tibial periostitis, and had areas of alopecia. Was under specific treatment when taken with typhoid fever, October 17, 1879. Specific treatment stopped and carbolic acid and iodine tincture substituted. Recovery from typhoid fever was perfect, and there have been no indications of syphilis since, although he has had no specific treatment.

CASE VI.—P. J., æt. twenty-three years, had been affected with chancre, papular syphilide, and sore throat. At the time he was taken with typhoid fever, September 5, 1885, he was under treatment for lung syphilis, was emaciated, had cough, mucopurulent expectoration of offensive odor, night sweats, fine crackling and mucous râles, and some dulness on percussion over the lower and middle portions of the left lung. At the outset of the acute febrile process, it seemed in the highest degree probable that phthisis pulmonalis held sway, but as the abdominal typhoid symptoms became more pronounced, the pulmonary trouble abated and the characteristic temperature curves of typhoid fever, in the days before antipyretics, were established. The disease was of a severe type, ran a protracted course, but with convalescence the patient became very robust, and has enjoyed the most vigorous health ever since.

It may be urged that gonorrhœa is a self-limited disease, and will run out of itself if left alone; but the case of gonorrhœa has not come to my knowledge that has ceased of itself within a few weeks. Gonorrhœa existing in connection with other diseases, as pneumonia and acute rheumatism, has outlasted them in every instance, and required treatment in order to bring it to a close. The suggestion also has bearing that iodine and carbolic acid are excreted in the urine, and that, in consequence of their administration, the clap was cured through the resolvent action exercised upon the urethral mucous membrane by the flow of the carbol-iodized fluid over it, or by the germicidal properties of these substances upon the gonococcus. This, however, involves the concession of the same potency to naphthol, with which one case was exclusively treated. It is possible, of course, that a good treatment for gonorrhœa may be here revealed, but not at all probable since all of these agents have been tried and found wanting when applied directly to the seat of the trouble by urethral injections. Yet it is also true that copaiba, which, when given internally, cures gonorrhœa in the majority of instances, fails of its effect when injected into the urethra. But anti-microbic influence has never been ascribed to it, and to some special inhibitory and resolving power over urethral inflammation must be accredited its beneficial action.

In both syphilitic cases the iodine tincture found exhibition, and to this substance, may be thought by some the amendment should be attributed. While iodine, combined with alkalies as the iodides, everywhere finds favor as the remedy, *par excellence*, in tertiary syphilis, it will hardly be accepted that so intractable a disease has been rendered latent or cured by a three weeks' course of tincture of iodine. On the contrary, uncombined, after long and ample trial, it has been discarded as inefficacious.

It is well recognized that after perfect recovery from typhoid fever, the former subject of it attains a condition of unusual vigor, and enjoys an immunity from disease for a considerable number of years. The common acceptation is that the disease, by causing depletion and waste of tissues through arrest of nutritive processes, has eliminated all peccant substances from the system, and restored all organs to a perfectly normal-physiological state. The physical well-being and power of resisting disease which ensues after typhoid fever, however, is susceptible of another interpretation.

The pathogenesis of disease is being more and more narrowed, and microscopic organisms have assumed a proportion in relation thereto in indirect ratio to their size. The microbe of typhoid fever has been isolated, and the claim is made that that of syphilis has also been discovered, presenting characteristics by which any skilled microscopist may readily recognize it. The gonococcus of gonorrhœa has become a familiar entity, and its movements are now observed by microscopists with the same complacency as those of a playful kitten. These diseases then, according to the most advanced scientific dicta, belong to the family of germ diseases. It follows then that the special parasite which produces them, as is known to be the case with all forms of life, high or low, has a

Nemesis among its fellows which only needs to be encountered to insure destruction or abdication. In horticulture, as is cognizant to all, where parasites infesting plants become inimical to their cultivation, they are disposed of by the employment of antagonistic parasites, which are less prejudicial to plant growth and development. In combating germ infection in the higher animals, antagonistic organisms have not as yet come into prominence, although they promise to figure largely in the medical measures of the future. In the human subject one step in this direction has been taken recently. A Russian physician, whose name has been strangely withheld by the abstract editors of our medical press, has inoculated fourteen persons suffering from diphtheria with a cultivation of the microbe of erysipelas. His results are reported as very successful, twelve cases recovering, and in the two fatal cases the inoculations failed. Ricord, Depres, Busch, and Kleebatt had before employed cultures of the erysipelas coccus for inoculating malignant tumors, with results more or less favorable.

It is not altogether improbable then that the microbe of typhoid fever is a foe to other pathogenic forms, and by causing their extinction brings about the usually long-continued good state of health which ensues after a course of that disease. In this way it is possible to account for the amendment in the cases of venereal disease forming the basis for this paper. If any one is inclined to shrug his shoulders in regard to the germ origin of disease, it is only necessary to go backward a little to the ideas of special infecting principles, or viruses, or poisons. These will answer equally as well to frame a probable hypothesis of the eliminating element in these cases. The antagonism of poisons is too well appreciated in medicine to need elaboration, and a stand may be made upon it as upon an impregnable rock.—*Cincinnati Lancet-Clinic*, Aug. 2, 1890.

Uterine Vomiting Independent of Pregnancy.—Much has been written of late years on the subject of the vomiting of pregnancy and its most aggravated form, hyperemesis gravidarum or uncontrollable vomiting. Dr. P. Lamy has recently written on cases in which troublesome vomiting has been observed as associated with other phenomena of the female generative system besides pregnancy. He began with a case of vomiting at puberty. A girl, aged fourteen, suffered severe pain before her first period. After that period the pain ceased, but an attack of vomiting followed every meal. No drugs were of any avail, and the patient had to be fed with a drachm of beef-tea every half-hour. When the menses became regularly established the vomiting ceased, and did not return during the first pregnancy six years later. Dr. Lamy related two obstinate cases of vomiting during the period in adult women. In one, vomiting invariably followed sexual intercourse. The patient became pregnant, but after she bore a child the vomiting always returned under the same circumstances as before. Treatment proved unsatisfactory. Lastly, Dr. Lamy noted a case of vomiting at the climacteric. The patient was fifty years old, the period was becoming very irregular, and occasional disturbances of the alimentary canal, especially vomiting, set in. Treatment, as in ordinary dyspepsia, gave relief. This last case might be explained by many physicians as simple gastric catarrh, due to errors in diet or other causes, rather than to changes in the uterine functions. It is clear that the vomiting of pregnancy is very common and almost normal, in the sense that a certain amount of hemorrhage at delivery is normal. On the other hand, vomiting at puberty, during menstruation, after coitus, or about the menopause must be considered abnormal.—*Brit. Med. Jour.*, July 19, 1890.

Allen (J. M.) on Gastro-Intestinal Irritation with Report of Cases.—The author reports cases of eczema, pruritus, neurasthenia, epilepsy, and insanity (melancholia), in which he attributed the disease to gastro-intestinal irritation.

In a general way his treatment is as follows:

Of first importance in each and every case, is the food, which should be as near as possible albuminoids in a liquid form, so as to leave no work for intestinal digestion, thereby giving these organs rest. In acute cases, small doses of opium, repeated often enough to control peripheral irritation, are indicated. Bromide of potassium and ergot, if there be hyperæmia of nerve centres. Where opiates for any reason are objectionable, I have found much benefit from belladonna. In enteric fever, where there is a tendency to nervous complications, I begin this course early, and have had satisfactory results. In chronic inflammation or ulcer-

ations I rely mainly on the subnitrate or salicylate of bismuth, pulv. hydrastus, and creosote—creosote being my sheet anchor, given in one- to two-drop doses three times daily.

It is often necessary in chronic cases to use small doses of opiates two or three times daily. Carbolic acid is also of much benefit. Counter-irritation twice daily, at fixed hours, morning and evening, is of great benefit. Where membranous enteritis exists, in addition to the above, I have great faith in the intestinal germicides, creosote, carbolic acid, salol, bi-sulphide of carbon, sulphuret of potassium, fl. sulphur, and the oil of eucalyptol. When the inhibitory nerves of the heart are implicated, digitalis is of great benefit. Nux vomica and its salts are indicated and of benefit when there is anæmia of the nervous system. At a point where tonics are indicated, Churchill's hypo-phosphites are the most beneficial, or the bitter tonics in the form of infusions. The ferruginous preparations, when given by me, have uniformly been injurious. Nor have I received any benefit from the acid tonics, except the dilute sulphuric. All possible aid that can be given to the stomach to aid its functions in digesting the food should be given. Excessive acidity of this organ should be controlled by appropriate doses of the bicarbonates of soda and potassium. Alcoholic compounds should be avoided as injurious.—*Kansas City Med. Record*, July, 1890.

The Mortality of Widowers from Phthisis.—In a paper on tuberculosis in Belgium, MM. Destrée and Gallmaerts come to the conclusion as the result of their investigations that, in comparing the mortality from phthisis of bachelors, married men, and widowers, the last are very much more subject to this disease than either of the other classes. The same statement holds good for all ages, and it is, they say, also true that widows are more liable than single women to die of phthisis. The authors do not think this is to be explained except by direct contagion of wife to husband or husband to wife. They cannot think irregularities and excesses indulged in by widowers can be answerable for it, for advanced age does not seem to make any difference. They would ascribe it to infection occurring during married life, the disease claiming its second victim some time after the death of the first.—*Lancet*, Aug. 2, 1890.

Rousseff (M.) on the Relations Existing between Intestinal Tuberculosis and Stomachic Alterations in Pulmonary Tuberculosis. — In chronic pulmonary tuberculosis the intestinal tuberculosis depends upon the state of the stomach. This organ, modified in its structure by either parenchymatous or interstitial inflammation, or by amyloid degeneration, can no longer discharge its functions normally, and cannot be an obstacle against the invasion of the bacillus. Intestinal tuberculosis is always preceded or accompanied by a pathological condition of the stomach. A capital point in the treatment of tuberculosis should be attention to the state of the stomach, either in preventing the modifications which may appear or in treating these modifications, for intestinal tuberculosis, added to the pulmonary, quickens the course of the disease. Man, on account of his life being more abnormal, and gastric troubles resulting from this, is oftener attacked by intestinal tuberculosis than woman (during the course of pulmonary tuberculosis). The age of the patient, the degree of pulmonary lesion, and its duration, have no very great influence on the production of intestinal tuberculosis. Pulmonary tuberculosis by itself cannot directly produce a gastritis which would permit of a tuberculization of the intestine. Translated by C. G. Cumston.—*Dublin Jour. Med. Sci.*, Aug., 1890.

Wood (H. S.) on a Case of Hyoidean Dislocation in Pulmonary Phthisis.—A hurried message was sent to say "that the patient, H. L., had displaced a bone in his neck, and that he was choking." On arriving, the patient, aged about twenty-seven, was sitting up in bed with his arms crossed over the upper part of the thorax, one hand grasping the upper portion of his neck, as if to steady the hyoid bone, and the other steadying the larynx. His face was much emaciated, and wore an aspect of distress; there was slight cyanosis; but the symptom most complained of was a feeling of impending suffocation. The head was thrown slightly forward on the chest in order to relax the muscles. The patient at first could not be persuaded to let go his hold on the neck, but after a little while he did so, and then we saw clearly the exact state of affairs. There was a certain degree of prominence on the left side of the neck, in the region of the submaxillary triangle;

on feeling for the hyoid body, it was found to have deviated from the mesial plane of the neck. On running the finger along the greater cornu, the tip of the horn was found to be displaced upward and to the left, so as to be on a level with the angle of the inferior maxilla. It was evidently a dislocated hyoid. No crepitus could be detected. Reduction was effected by making the patient swallow; and while fixing the thyroid cartilage with one hand, the bone was pushed in the opposite direction to the displacement, and went in with a perceptible click and a slip, much to the patient's relief, the dyspnœa improving directly. The bone was kept in position by means of two pads, one on each side of the hyoid, and a bandage round the neck. The bone has since been dislocated in a slight degree, but reduction was effected in the same way. According to the patient's statement, the bone was displaced during a violent paroxysm of coughing, with the head bent laterally to the right side. Physical examination revealed extensive tubercular disease of both lungs, an empyema on the right side, and extensive disease of the larynx, epiglottis, and neighboring parts; the voice was very feeble, and almost reduced to a whisper. On referring to the subject in Holmes' "System of Surgery," I find a case of Dr. Gibbs quoted; and in the above case the only cause which appears feasible to my mind is that, owing to the degenerative and ulcerative changes in the neighborhood of the hyoid bone and laryngeal cartilages, the ligaments must have been relaxed, or may have undergone a certain degree of softening; at the same time the muscles arising in and inserted into the hyoid must have lost their normal tone, partaking in the general debility, and so predisposing to the dislocation, which was actually brought about by a paroxysm of coughing. The method of reduction is somewhat different from that described in Holmes' "System of Surgery," but, owing to the urgency of the case, there was no opportunity left to inquire as to the exact method of reduction.—*Lancet*, Aug. 2, 1890.

Emerson (J. H.) on Congenital Stenosis of the Duodenum; Hæmatemesis; Death on the Fifth Day; Autopsy.—N. B., male, the fifth child of healthy parents, was born on April 24th after a normal and easy labor of about fifteen hours. Weight, eight pounds and a half; circulation perfect. Appeared well nourished and well developed in every respect. When about thirty-three hours old the child suddenly and without any apparent cause spat up or regurgitated about half an ounce or more of rather dark blood, partly mixed with mucus. This effort involved some choking, and was followed by some blueness and coldness of the extremities. The same thing was repeated at intervals for eight or nine hours. Before the blood spitting, a dark tarry stool had been passed. The child would not nurse or take food. All attempts at medication resulted in increased regurgitation of blood.

When three and one half days old the child vomited a large quantity of dark-brown, watery, and grumous fluid, which also poured through the nostrils, and a similar discharge took place now and then in greater or less quantity, and not always with an effort of vomiting, until his death, which occurred when the child was four days and ten hours old, emaciated, but not extremely exsanguinated.

Autopsy: Foramen ovale patent, $\frac{5}{8}$ inch. Stomach much dilated, greater curvature, $6\frac{3}{4}$ in. Pyloric orifice dilated, $\frac{1}{4}$ in. in diameter. Duodenum much distended, over 1 in. in diameter until point of entrance of common bile duct, where lumen of gut seemed occluded, neither fluid nor air passing through. A medium-sized probe could be passed through the constriction. Intestines below stricture normal and empty. Immediately above cardiac orifice of stomach is a firm, darkened, oblong thrombus 1 in. long firmly attached to posterior wall of the œsophagus, which was at that point eroded.—*N. Y. Med. Jour.*, Aug. 9, 1890.

Taylor (C. H.) on a Case of Scarlet-Fever, Measles, and Diphtheria Running Together in the Same Individual.—E. W——, aged four years and a half, was admitted March 29, 1890, suffering from scarlet-fever. She had a typical rash, with sore throat and tongue. Temperature 103.2°. The fever ran an ordinary course, and on April 19th she was peeling generally, the throat being still somewhat swollen, and the glands of the neck enlarged. On April 10th, twelve days after admission, the child began to sicken again, and complained of headache; the temperature began to rise, and there

was marked coryza. On the 11th she had a rigor (temperature 105.4°), and the following morning presented a well-marked measly eruption over the face, neck, and wrists. April 13th: Rash disappearing; temperature falling; child seems better; throat still inflamed. 14th: Temperature 104°; patches of membrane seen on both tonsils. 15th: Membrane on soft palate, removal of which causes bleeding; much difficulty in deglutition, and also in respiration; symptoms of laryngitis appearing. 17th: Respiration still difficult; quantity of muco-purulent discharge from nose; throat less inflamed. 23d: Child seems better; takes nourishment well; tongue cleaner; ulcers on tonsils, but no membrane to be seen; respiration much easier; pulse fairly good. 24th: Has had two slight attacks of syncope while sitting up to be fed; seems unable to swallow in the recumbent position. 25th: The child, after awaking from a short sleep, was rather restless, had another fainting attack, and died.

Remarks: When the membrane first appeared on the tonsils we were doubtful as to its nature, and inclined to look upon it as merely an aphthous condition arising in the course of a specific fever; but from the way in which it spread to the larynx and nasal cavities, and the subsequent development of the general symptoms, we were induced to look upon it as a case of diphtheria, and to treat it accordingly. It is not uncommon for measles to supervene during an attack of scarlet-fever, or for diphtheria to attack a patient suffering from either measles or scarlet-fever, but the occurrence of the three together is, I think, of such rarity as to be worthy of recording.—*Lancet*, Aug. 2, 1890.

Lanphear (E.) on the New Treatment of Peritonitis. — The author's conclusions are:

(1) The saline treatment should be adopted early in simple, acute peritonitis.

(2) Small doses of calomel may be given to mild purgation in cases seen after the disease is fully developed.

(3) Cases which fail to be relieved by cathartic measures should receive early operative interference.

(4) Whenever peritonitis has gone on to that stage where the formation of pus is known, or even suspected, to have taken place, abdominal section and drainage are imperatively indicated.

(5) When the existence of tubercular peritonitis is diagnosticated, or strongly suspected, operation (exploratory incision) is justifiable.

(6) Opium is only indicated in the second stage of peritonitis, and then not because it "forms a splint," but because it relieves pain, sustains the heart, and prevents shock—thus combating the tendency to death.—*Kansas City Med. Index*, July, 1890.

Horwitz (O.) on a Case of Pruritus Universalis, Produced by the Passage of a Bougie.—The patient was a man, who had masturbated and committed sexual excesses. He had symptoms of sexual neurasthenia, and a very irritable urethra, which was narrowed to 20 F., just back of the orifice. An epileptiform convulsion followed the passage of an exploratory bougie. The meatus was enlarged, and the stricture cut to admit a 35 F. meatus bougie. At the end of three days a 31 F. was passed into the bladder. Three days later the same operation was followed by an agonizing general pruritus, lasting in diminishing severity eight or ten days. This operation was repeated three times, and always with the same result. The connection between the passage of the bougie and the itching seeming more than a coincidence, all further sounding was stopped.

A six-per-cent. solution of cocaine was injected into the urethra, and having passed a Winternitz psychrophor, water at the temperature of 57° F. was introduced into the instrument, reducing the temperature of the water at the end of five minutes to 52° F. A spinal ice-bag was applied to the lumbar region every night before retiring for the space of one hour, massage used every morning, and a Turkish bath once a week. Later, after the patient began to convalesce, the following remedies were prescribed: Sulphate of quinine, sulphate of iron, of each 2 drachms; phosphate of zinc 2 grains; sulphate of strychnine, ½ grain: divided into forty pills, of which one was taken morning and evening. Under this treatment the patient rapidly recovered. He has since married.—*Med. News*, Aug. 9, 1890.

Nervous Symptoms Consecutive to Double Castration.—It is curious that so little should be known in respect of the nervous and psychical troubles following removal of both testicles. Tradition tells us that eunuchs castrated before the advent

of puberty assume certain feminine characteristics in respect both of mind and body. When the operation is performed after puberty the corporeal changes are naturally less well marked, but the victims become irritable, melancholic, and devoid of energy and initiative. Although in Russia and elsewhere there exist sects, such as the Scopzys, who practise self-mutilation, their votaries do not afford much help in observing the effects of the deprivation, because nervous and psychical derangements may be supposed to precede the operation. Those who have to submit to the loss of the testicles for surgical reasons are by no means numerous, and they invariably withdraw from observation as soon as the wound is healed; and, moreover, the condition of their nervous system is usually masked by the predominating influence of the diathesis (often tuberculous), the local manifestations of which have necessitated the operation. In regard to females, our data are more numerous and exact. The climacteric period is well known to be associated with nervous and psychical troubles, and at this epoch the character and temperament become modified. Mental disease is frequent at this period, and the same morbid phenomena seem to result from the artificial menopause brought about by double castration. The most frequent symptoms are due to vaso-motor disturbances, which may go so far as to cause vertigo, and even simulate epilepsy. The psychical symptoms belong to the melancholic type, and not uncommonly culminate in dementia and suicide. Eleven out of thirty-three women operated upon were found by Glaewecke to have developed these symptoms. According to Brown-Séquard, they are attributable to the withdrawal from the blood of secretions, the reabsorption of which usually had an activating effect on the system generally.—*Med. Press*, July 16, 1890.

Poole (T. D.) on a Case of Influenza and Aphasia.—A woman of twenty-seven was confined about the middle of March and in eight days was up and well. On April 11th she was suddenly seized with shivering, giddiness, and a violent frontal headache. When asked how she was she said: "I don't know, I feel queer," and pointed to her head. She was given brandy and put to bed and it was soon noticed that she had lost the power of speech. The next day she seemed confused and could only answer questions by the monosyllable "yes." The temperature was 100.2°, the pulse quick and weak. A saline and some quinine powders were administered and brandy and egg was given several times a day. On May 9th the aphasia was much better but she still complained of headache.—*Edinburgh Med. Jour.*, Aug., 1890.

Sinclair (G. L.) on the Treatment of General Paresis.—If you were able to diagnose such a case in its very early stages, it would be best to send the patient away to the country in charge of a good nurse and *without the wife*. The trouble is that a patient will not listen to suggestions of being in any way ill or submit to any restriction upon his personal liberty. Absolute rest from mental work is urgently demanded and should be obtained if possible.

When the patient is admitted we inquire as carefully as we can into the history of his past life to see if there is any reason to suspect syphilis. If we find any record of venereal disease, we give iodide of potash, in large and increasing doses. Bichloride of mercury has been advised and has been used, but with no specially good effect.

For the excitement which is very frequently present, and which has often a rapid heart action, I have found nothing better than tr. digitalis and bromide of potash—in full doses. The patient should be kept as much as possible in the open air. His bowels should be regulated by some form of aperient, and I am rather partial to one of the mercurials. His food should be sufficient and nourishing, but these people are very apt in the early stage to overeat and they should not be permitted. When the patient sleeps badly or is noisy some form of hypnotic is called for. I do not like to use either morphia or opium. The after effects are undesirable. We have tried tr. digitalis in large doses as a sedative, but are not very well pleased with the effect; better results have followed in our hands the use of chloral hydrate, in 30- or 40-gr. doses, and still better the hypodermic use of hydro-bromate of hyoscine in doses of gr. $\frac{1}{100}$ or $\frac{1}{150}$. This is as certain to produce quiet and sleep as any drug with with I am familiar.

For the epileptoid seizures, if they continue, or fail to be controlled by having the patient in bed with cold applications to the head, I inject gr. $\frac{1}{4}$ of morph. sulph. hypo-

dermatically, and generally the effect is marked, and promptly stops the convulsion. In two cases, strong plethoric men, I bled freely from the arm. Here also the result was curative of the fits. As the disease advances and the patient becomes more paralyzed, special attention must be given him during meal times, to prevent choking. His food should be cut up and he should be fed by the nurse; keep such patients out of bed as long as possible. When the stage of absolute inability sets in, every thing must be done to prevent the formation of bed-sores. If possible, a water bed should be under, failing this an elastic spring bed, and the patient changed from side to side. So liable are these sores to come, that even if one limb lies across the other for a short time, this slight pressure will cause a blister to form, and this speedily will enlarge and become a stinking, spreading sore.

During this last stage the patient emaciates rapidly, although taking a fair amount of food. This should now consist entirely of liquids, especially milk and its preparations. Swallowing is badly performed, and there is liability of solid food becoming lodged in the pharynx and choking a man to death. The bed-sores should be kept clean and dressed with powdered oxide of zinc., and over this a layer of soft picked oakum placed round, with a few strips of sticking-plaster. Sooner or later diarrhœa occurs, and carries the patient off, or a series of convulsions sets in and death results. I may mention to you that quite recently the surgeon has stepped in and trephined the skull of paretics, then punctured the membranes and drained off some of the fluids which are in excessive quantity within the cranium. In two cases reported amendment has followed—but the time is not long enough since the operation was performed to say that cure has resulted. The theory is that by relieving tension which the excessive fluid accumulation causes, the nutrition of the brain is improved, and that good will follow which may be permanent. Further experience and more cases are required to establish the wisdom of the treatment or the truth of the theory.—*Maritime Med. News*, July, 1890.

Vaughn (V. C.) on the Fundamental Factors in the Causation of the Infectious Diseases.—The author concludes that:

1. All toxicogenic germs are dangerous, when introduced into the body.

2. Filth may and does breed disease.

3. It is not necessary that milk should contain a specific germ in order to poison the child, or that a water should contain Eberth's germ in order that it may induce typhoid fever.

4. Whenever man builds for himself a habitation, and poisons the soil about him and the water which he drinks with his own excretions, there will be enteric fever.

5. A good digestion and a healthy gastric juice does aid in the prevention of disease.

6. We can still continue to treat consumption by good, generous feeding and constitutional treatment, without the risk of being denounced old-fogyish and unscientific in our practice. Such practice is more scientific and more successful than the fads of the rectal administration of hydrogen sulphide gas and the inhalation of hot air, which have been imported in recent days from France and Germany. Our fathers, who treated tuberculosis with cod-liver oil and recommended out-door exercise, but who carried no gas-bags nor knew any thing of the Weigert oven, were not such fools, after all.

In conclusion, let us state that the germ is only one of the factors in the causation of the infections diseases. The other factors are to be found in disordered digestion and impoverished blood.—*N. Am. Practitioner*, Aug., 1890.

Hunter (W.) on Observations on the Treatment of Pernicious Anæmia Based on a Study of its Causes with Notes of a Case.—If the trouble depend on the presence of internal parasites, such as bothriocephalus latus or auchylostoma duodenale, they must be removed by appropriate medication and purging. When it is due to gastritis or atrophy of the mucous membrane of the stomach, the stomach should be subjected to systematic washing, and arsenic and occasionally phosphorus or beta naphthol may be advantageously employed.

The most important symptom to combat is the excessive destruction of blood, and this is best done by a regulation of the diet, which, the author insists should be more farinaceous than nitrogenous, as he claims the latter intensifies the destruction of blood. —*Brit. Med. Jour.*, July 12, 1890.

MISCELLANY.

Woodbury (F.) on Somnal, the New Hypnotic.—Last fall Radlauer,[1] of Berlin, brought to the notice of the medical profession a new compound to which he gave the name of somnal, in acknowledgment of the remarkable hypnotic properties which it appeared to possess. It was formed by the union of chloral, alcohol, and urethan, according to the original notice,[2] but is not a simple mixture of these bodies. It differs from chloral-urethan by the addition of $C_2 H_4$, its formula being $C_7 H_{12} Cl_3 O_3 N$. The method of manufacture is by direct combination of chloral alcoholate and urethan in a vacuum apparatus, according to its discoverer who states[3] that its composition might be graphically represented thus:

$$\begin{array}{l} \quad\quad OC_2 H_5 \\ C\,Cl_3—C—H \\ \quad\quad NHCOOC_2 H_5. \end{array}$$

Somnal is a colorless liquid, resembling chloroform in its appearance and behavior when added to cold water, in which it forms globules and refuses to mix or dissolve. When shaken with water, the mixture is milky but quickly separates. It is soluble in hot water and alcoholic solutions, and dissolves resinous substances and fats. The odor is faint, not very penetrating or disagreeable, and resembles that of the spirits of nitrous ether, or recrystallized chloral. The taste is very pungent; and for administration it needs free dilution. It may be given with whiskey or solution of tincture of zingiber or syrup of licorice. Somnal is inflammable, burning with an alcoholic flame; it does not evaporate quickly, and leaves a greasy stain upon blotting paper. Specific gravity greater than water; reddens litmus paper slightly.

Physiological Effects.—In its action it resembles chloral in quickness of effect and naturalness of the sleep produced. No marked depressing influence was exerted upon the pulse or respiration rate, though it was noticed that the breathing became slower and the pulse slower and fuller as in natural repose. No disagreeable after-effects. The head was clear and the stomach was unaffected; the patients generally had an appetite for breakfast. No constipating effect. The kidneys acted rather more freely than usual. My colleague, Dr. Ernest Laplace, to whom I gave some of the drug for trial at the Philadelphia Hospital, writes as follows:

"I have given somnal a fair trial upon six patients at the Philadelphia Hospital. In no case was the patients told what was given them, so that outside of the bare possibility of the patients' falling asleep through natural causes, somnolence was brought on by the drug. It was administered in a solution of tinct. zingiberis, in half teaspoonful doses, and was found palatable.

"Administered at 4 P.M., at a moment when patients were not generally asleep, in four cases sleep came on within half an hour, which lasted from five to eight hours, the two other cases showed no effect from the drug. It is their habit to get at least gr. ¼ of morphine sulph. to put them asleep every night, as they are sufferers from intractable malignant growth.

"In no case was there any noticeable after-effect.

"I have not formed any opinion upon the length of time that the drug could be used daily upon the same patient.

"To this I might add that no depression of the normal temperature was noticed in any case in my hands, and thus far I have not used it in pyrexia."

Therapeutic Application.—The effect of somnal in producing natural sleep suggests its use in insomnia. The first case in which I used it was in a patient suffering with acute alcoholism, who had been under treatment for a fortnight in an institution, where he had a free supply of liquor, and he came out rather worse than he went in. He was 39 years of age, very tremulous, and could not sleep, or if he dozed off would immediately waken up. I gave him, at about 3 P.M., thirty minims of somnal (or rather a drachm of a mixture of equal parts of somnal and whiskey), well diluted, and went into an adjoining room to speak to an attendant. Upon my return I was surprised to find him fast asleep, although I had not been away from him more than fifteen minutes. He slept for four hours, and then was able to take something to eat. At ten o'clock he had another dose and he slept until seven next morning, having wakened up once only during the night and insisted upon having another

[1] *Zeitschrift des Apothekers-Vereins*, Nov., 1889.
[2] *Journal de Médecine*, Oct. 20, 1889.
[3] *Pharmaceutical Journal and Transactions*, Nov., 1889.

dose, and immediately after taking it he fell asleep again. The next night he was given a double dose at 10 P.M., and he slept all night without wakening. No bad effects were observed. The somnal was given for four nights, when he was so nearly well that it was suspended, as he had had good natural sleep at night and seemed quite restored. Alcohol was positively prohibited, the only substitute allowed being elixir of coca and camellia in tablespoonful doses, in which it is true there was a small amount of alcohol, which was quite infinitesimal when compared with what he had been using. Somnal, therefore, acts well as a hypnotic in acute alcoholism as a tranquillizer and hypnotic.

In a case of neuralgia of the bowels (visceral neurosis of Allbutt), where the patient had a sleepless night, a dose of twenty minims relieved nausea and pain, and the patient fell asleep.

In syphilitic headache and insomnia, somnal in moderate doses failed to produce sleep, which was afterwards secured by potass. bromide and iodide, and antipyrine.

In cases of insomnia, fretfulness, and restlessness in young children, somnal with mint-water and syrup offers better results than opiates, and is much safer. The same remark probably applies to the use of somnal in acute pneumonia, but I have not been able to confirm this yet by actual trial.

Without further going into detail it may be stated in conclusion that somnal acts as a hypnotic, but instead of depressing the system as chloral does, it slightly stimulates the gastric mucous membrane, relieves nausea and pain, and improves the appetite, increases secretion (probably), does not cause constipation. The circulation, respiration, and temperature are not notably depressed after its administration. No disagreeable after-effects have been observed. As it is rapidly eliminated from the body, it may be administered each night for a number of days without any obvious ill-effects. It acts very much like chloral, but is more pleasant to take and not so depressing in its effects upon the nervous system and the circulation.—*Dietetic Gazette*, July, 1890.

Roosevelt (J. W.) on the Gross Anatomy of Chronic Pulmonary Consumption.—For clinical purposes we may describe a discrete and diffuse form of consumption.

The discrete form is not at first easy to recognize, since abnormal signs often are absent and the bacillus absent or hard to find. The physical signs in this form are not to be regarded as of value in prognosis, while in the diffuse form they are fairly trustworthy.

The diagnosis of commencing consumption must be made from the patient's history, quite as much as from physical examination of the chest or sputa. If we wait too long in order to become certain in diagnosis, we also quite often permit our patient to become certain to die. It is better far to run the risk of making an incorrect diagnosis by concluding that the disease exists when it does not, than to run the risk of jeopardizing, or possibly needlessly sacrificing, a life for fear of a diagnostic error.—*N. Y. Med. Jour.*, July 19, 1890.

Mosny on a Case of Erysipelatous Broncho-Pneumonia.—A woman aged thirty-seven, a domestic, while attending her master affected with erysipelas of the face, fell ill and was sent to the hospital, presenting all the symptoms of primary pneumonia, without any morbid manifestation either on the skin or in the respiratory mucous membranes. The disease proved fatal, and at the necropsy the streptococcus erysipelatis was found in the exudation from the lungs. Three drops of a recent culture injected under the skin of the ear of a rabbit produced the ordinary experimental erysipelas, and it was concluded that this case was one of primary erysipelatous broncho-pneumonia.—*Lancet*, February 22, 1890.

Flint (W. H.) on the Dosage and Administration of Creasote in Phthisis.—1. That intrapulmonary and intratracheal injections of creasote are of doubtful utility, and may be positively injurious.

2. That for administration by mouth or rectum, solutions and emulsions of creasote are preferable in most cases to capsules, pills, or wafers.

3. That milk is an excellent vehicle for the administration of creasote in solution or in emulsion.

4. That each method of administering creasote used by the writer—viz., by inhalation, by mouth or rectum alone, and by both these channels simultaneously—is useful, and may each be particularly adapted to individual cases. In suitable cases

the most rapid progress seems to be made when all these ports of entry are utilized.

5. That the best results for each individual attend the administration of the maximum quantity of creasote which this patient will bear.

6. That the average patient will not easily tolerate more than ten or fifteen minims of creasote *per diem* for any great length of time, and that many will only bear two or three drops *per diem* continuously administered.

7. That it is very important that the treatment be uniform and uninterrupted.

8. That, consequently, an effort should always be made, if intolerance of creasote is shown by any one mucous surface, to employ some other channel of introduction, in order that the continuity of the treatment be not interrupted.—*N. Y. Med. Jour.*, July 26, 1890.

Phelps (A. V.) on Intra-Urethral Chancre.—A gonorrhœa and an indulgence in alcohol, and we have the most frequent form of acute urethral stricture. Rarely does inability to urinate result from a chancre in the urethra.

Such a case, however, was seen recently at the clinic, having the history of a purulent discharge from the urethra for several weeks, and of difficult urination for a few days. The first two days of the dysuria the urine passed from the bladder down the urethra to the obstruction, where it was arrested, and then followed most painful vesical tenesmus, while the urine slowly dribbled away. On the day the patient applied to the clinic his dysuria had become a retention.

An induration of the urethra was found about an inch posterior to the meatus. No soft instrument, however small, could be passed; the first thing to go through the stricture was a small, blunt-pointed probe. After the probe had lain in the urethra for some minutes, a small blunt-pointed silk-bougie was passed, and then a larger, the urine passing through the canal, thus dilated, with something like comfort to the patient. Thus started, dilatation was easily continued.

Not always is it so easy to dilate. A private case had such marked induration, that the patient could only urinate immediately after a hard instrument was withdrawn; at other times the urine was arrested, and the patient doubled over from the violence of the vesical tenesmus following.

Bougies, made of white wax three parts, and mercurial ointment one part, being quite hard, were used in this way. The urethra, the first time, was dilated with a hard instrument, then the wax-bougie was passed and held in place by a bit of cotton fixed under the prepuce, as cotton is fixed to catch gonorrhœal discharge. When the patient wanted to urinate he pulled out the bougie, and the urine followed. Immediately after urination another bougie was inserted.

These cases are often diagnosticated and treated as clap. The purulent discharge, quite free at times, is from a urethritis, due to irritation from the thin, slight discharge of the chancre. Careful examination only is necessary to find the induration, usually seated near the meatus. A sign I have often noticed, and never in any other condition than in primary syphilis, and then most frequently when intra-urethral, is hardening (infiltration) of the lymph-vessels on each side of the prepuce, at times causing phimosis, at other times extending to the vessels on the dorsum of the penis, where they feel like quills under the skin. A violent gonorrhœa may cause an œdema of the prepuce, but I have never seen with it the hardened lymphatics.

No matter what may be one's notions about constitutional treatment before the secondary symptoms appear, it is proper to push it in these cases.

The wax-mercurial-ointment-bougies act specifically, and cause, as well, absorption by pressure. Inunctions over the chancre may be made. Calomel, one-fourth grain, three times daily, may be given internally. —*Jour. of the Med. College of Ohio*, June, 1890.

Southam (F. A.) on the Use of Antiseptics in the Treatment of Urethral Stricture by Internal Urethrotomy.—The following is the general plan of treatment which was carried out: Internal urethrotomy having been decided upon, the patient is confined to bed and kept upon a milk diet for a few days previous to operation, the urethra being meanwhile left at rest, and free from the irritation caused by the passage of instruments. To relieve any tendency to congestion of the urethral mucous membrane and parts about the neck of the

bladder, the bowels are kept freely open by small doses of sulphate of magnesia. A mixture containing boracic acid in ten-grain doses is also given three times daily; for in the majority of cases of stricture where operative interference is required chronic cystitis is also present to a greater or less extent, the urine containing more or less pus, and, if not alkaline, being either neutral or only faintly acid in reaction. Under a course of boracic acid given internally, it will generally be found that the urine, at any rate in the less severe cases, soon regains its normal acidity; at the same time a portion of the boracic acid being eliminated by the kidneys, and passing away in the urine, the antiseptic action of the drug is exerted directly on the mucous lining of the bladder. Thus the cystitis is relieved, the pus diminishes in amount or entirely disappears, and the decomposition of the urine in the interior of the bladder is also prevented. The result is that the urine, if toxic, is sterilized or rendered aseptic, and its contact with the surface of the urethral wound after operation is consequently innocuous.

Operation: The instrument I always employ for division of the stricture is Teevan's urethrotome, which is carefully carbolized. The patient having been anæsthetized, about a drachm of carbolic oil (1 in 16) is injected into the urethra. A ferret is passed through the stricture, and the urethrotome having been screwed on to this and made to follow it, the roof of the urethra at the point of constriction is divided from before backwards in the usual way. The instrument is then withdrawn together with the ferret, and the stricture is afterwards dilated by passing Lister's sounds, 9–12 to 12–15. A full-sized silver catheter is then introduced into the bladder, and the urine having been drawn off, the viscus is thoroughly washed out several times by injecting a saturated solution of warm boracic acid. About two ounces of the solution are left in the bladder, and as the catheter is withdrawn the urethra is also flushed out with the lotion. An iodoform bougie is then passed down the canal as far as the neck of the bladder, so that it may lie in contact with the urethral wall at the seat of division of the stricture. During the operation especial care is taken to protect the patient from exposure to cold, and in addition to the ordinary precautions the lower extremities are wrapped up to the hips in thick woollen bandages.

After-treatment: As soon as the patient recovers from the anæsthetic, ten minims of liquor opii sedativus are given, and the dose is repeated in a few hours if he is at all restless and complains of pain. He is directed to hold his urine for six or eight hours, if possible; at the end of this period, when he is allowed to pass it himself, the urine will generally come in a good stream. For a time micturition is attended by more or less pain and smarting, and in most cases the urine will be slightly stained with blood for the first day or two after the operation. On the following morning, if there is no sickness from the anæsthetic, the boracic acid mixture, which has been discontinued on the day of operation, is commenced again. On the fourth morning, either a cocaine bougie or a drachm of a 10-per-cent solution of cocaine is introduced into the urethra, and, after an interval of ten or fifteen minutes, Lister's sounds, 9–12 to 12–15, well carbolized, are passed through the stricture. By means of the cocaine the pain which usually attends the passage of an instrument for the first time after operation is more or less completely prevented. During the remainder of the patient's stay in the hospital, Lister's sounds are passed daily, and before leaving he is himself instructed how to pass a No. 9–12, which he is allowed to take away with him, so that in the future he may keep the stricture dilated by the occasional passage of an instrument, and therefore be independent of further surgical assistance. The average length of time spent in hospital after the operation in the six cases referred to was twelve days.

Contra-indications: I am of opinion that internal urethrotomy should not be performed in cases where the urine is alkaline and offensive, containing a large amount of pus, nor again in cases where it remains so after a course of boracic acid administered internally and continued for a fortnight or three weeks. When these conditions exist, they usually point to the presence of a severe form of chronic cystitis. Under these circumstances the stricture, if it does not yield to dilatation, is best treated by external urethrotomy, and at the same time the cystitis can be relieved by draining and irrigating the bladder through the perineal opening.

Provided that the urine is acid, I believe that a slight amount of pus in the urine is not a bar to internal urethrotomy; for this condition was present at the time of operation in four of the six cases above referred to—*Lancet*, June 14, 1890.

Rickets (B. M.) on Fifteen Cases of Gonorrhœa Recovering Practically without Treatment.—In the past seventeen months the author has managed fifteen cases, as explained later on. Their ages and occupations are given to show the influences to which they were subjected. Eleven were under twenty-nine years of age; four, from thirty to forty-two. All but one used beer or whiskey, or both. All used tea or coffee, or both. Six were clerks; three, street-car drivers; two, travelling salesmen; one, a conductor; one, a harness-maker; one, a lawyer; one, a laborer; and one, a merchant.

Of primaries there were nine syphilitics, two being over and seven under thirty. Of these in two there was no discharge at the end of nine weeks; in five, none at the end of twelve weeks, and in two none at the end of thirteen weeks. Two had balanitis. All ran the usual course. Two indulged in venery at or about the ninth week, resulting in an increased flow of yellow and thicker pus.

Of secondaries there were six, three being syphilitic. Three were over, and three under thirty. In three there was no discharge at the end of six weeks; in two, at the end of seven; in two, at the end of eight; in two, the discharge was never characteristic of the second stage, but changed from white to clear and albuminous. Four began in the usual way and ran the usual course, but shorter. Relapses were caused by the use of stimulants, wine, tea, coffee, pepper, etc.—sexual excitement, fatigue, the erect posture, walking, physical exercise, overloaded bowels, and over-eating.

Now, as to the management, this had been very simple. The first thing is to gain the confidence of your patient. Unless this is done your orders will not be faithfully observed. To begin, thoroughly move the bowels, and have the patient go to bed and keep upon his back for a week or so, and as much as possible. Suspend the privates; and have him abstain from beer and other stimulants, and venery. Let the food be very plain. As to complications, there were none; neither cystitis, buboes, orchitis, stricture, nor posterior clap.

The disease is self-limited. The author believes that many cases of stricture are due to strong injections. It is wrong and cruel to inject before the ninth week. In none of these cases was there any examination for the gonococcus. As to marriage, he would not advise a man to marry under two years. Not all cases are infectious even where we find the gonococcus. We may take the gonococcus and inoculate the lower animals and get a result, but inoculation with the discharge from a gleet is followed by no result. The author had said that he made use of no injections. Yet he had one case which fell into other hands, and one injection cured him. He would admit that one of these injections (he preferred the nitrate of silver) will help after the tenth week. Before that it is a cause of stricture. If injections are used they should not be allowed to be made by the patient. A five-grain solution of the nitrate of silver is strong enough. He had spoken of finding no strictures nor points of tenderness. He found one in which the calibre at the meatus was two-thirds. He cut it, but after a time it was its original size. A full-sized sound will do the same as astringents. It puts the mucous membrane on the stretch.—*Cincinnati Lancet-Clinic*, July 5, 1890.

Evans (E.) on a Case of Vomiting of Pregnancy Cured by Local Treatment of Cervix.—Mrs. S., aged twenty-seven, healthy; good personal and family history; six weeks pregnant, fourth pregnancy. Vomiting for past six weeks, getting worse all the time. Appetite fair, but vomits all food; vomits during night if she sits up in bed. Treated during past six weeks without benefit by two or more physicians. There seems to be no evidence of any gastric lesion. Bowels costive. Heart, lungs, and urine normal. Uterus anteverted. There is flexion of the cervix, which is large and abnormally hard, with a slight left laceration; the os red, eroded, and tender. I applied arg. nit. (gr. xl. to oz.) to os and cervix, and put in a boroglyceride tampon. This stopped vomiting for ten hours, when she had a fright, which produced symptoms of abortion (pain and hemorrhage); these were overcome by rest and opium. After a few days, on vomiting recurring, the treatment with arg. nit. and tampon was repeated (in all four times), and

in the course of ten days vomiting had ceased, and she went safely to full term. During first pregnancy she vomited the whole nine months; in second, vomiting stopped by local treatment in third month; aborted in third pregnancy.—*Montreal Med. Jour.*, June, 1890.

Extirpation of Seminal Vesicles.—Dr. E. Ullmann, of Vienna, reports in the *Centralblatt für Chirurgie* the first case of extirpation of the seminal vesicles. In a boy, aged seventeen years, castration was performed on the right side owing to tuberculosis of the epididymis, and a considerable swelling and solidity of the right vesicula seminalis was noticed at that time. Two months later extirpation of the vasculæ seminales was performed. The operation was performed in Professor Albert's clinic. Starting from the perineum, the anterior wall of the rectum was detached; both the vesiculæ seminales and the right vas deferens were removed. Perfect recovery followed. Dr. Ullmann recommends this operation in the primary tuberculosis of the epididymis when the epididymis of the other side is healthy, and the vesiculæ seminales tuberculous; also in primary tuberculosis of the vesiculæ seminales.—*Brit. Med. Jour.*, June 28, 1890.

A Remarkable Case of Rupture of the Uterus.—A patient was shown last week before the French Academy of Medicine with a history that is probably unique both in respect of the lesion and of her survival. In the course of a labor, obstructed by pelvic deformity, the uterus was ruptured, but at first laparotomy was refused. Twenty-four hours later version was resorted to, but though the trunk was easily brought down, the head remained fixed, and had to be detached. Laparotomy was then consented to, and on opening the abdomen, the practitioner found the head lying free in the cavity of the peritoneum, but it was only after a tedious exploration that he was enabled to identify the uterus, which was completely separated from its vaginal attachments, and was located in close proximity to the under surface of the liver. Only the Fallopian tubes and a few shreds of the broad ligaments remained. Though by no means sanguine as to the patient's chance of recovery, the practitioner put the uterus back in its proper position, and stitched it there as well as he could. Being in the country he naïvely tells us that no antiseptic precautions were possible. He did the best he could under the circumstances, and—most remarkable of all—the patient made a prompt and uninterrupted recovery. It would be unkind to criticize a line of treatment which was sanctified by such a brilliant and unhoped-for result, but one would imagine that the removal of the uterus would have afforded the best chance for the patient.—*Med. Press*, July 2, 1890.

Beard (Chas. H.) on Relief from a Grave Type of Epilepsy Following the Correction of an Exaggerated Convergent Strabismus.—Consultation was sought by a barber, aged fifty-two years, quite intelligent, in March, 1888, for intense pain of left eye and contiguous region of face. Condition commenced eight years previously and had steadily increased in intensity and frequency since. Epileptic seizures had the usual type of the "*haut mal.*" Patient had at time of consultation three or four seizures every twenty-four hours, otherwise healthy save an old-standing total deafness. The left eye was deflected inwards, so that only a portion of the cornea could be brought into view with a strong effort. This deflection had increased in same ratio as the pain. Under ether complete section of the internal rectus was performed and tendon resection and advancement of the external rectus. Recovery was prompt, and the result was correction of deformity and relief from all further epileptic seizure. Just before his death, in June, 1889, from a railroad accident, there was a slight return of strabismus and pain.—*Arch. Ophthal.*, April and July, 1890. A. T. M.

Clasen on Depilatory Powders.—Dr. Clasen says (*Monatshft. f. prakt. Dermat.*, 1889, ix., 541), that among the best depilatory powders are sulphohydrate of sodium and sulphide of barium. As to the sulphohydrate of sodium, he says that, used as a paste, one part to eight of water, and allowed to remain on for a very short time, it acts well. But it deteriorates very rapidly and is dangerous to give to a patient, as it is quite capable of producing scars. The sulphide of barium is a safer powder for the purpose. It may be used by mixing fifty parts of it with twenty-five parts each of starch and oxide of zinc. This is mixed with water so as to form a soft paste and spread upon the face. After ten minutes it is scraped off and leaves a smooth skin.—*N. Y. Med. Jour.*, June 28, 1890.

C. W. C.

THE MEDICAL ANALECTIC AND EPITOME.

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE.

EDITED BY R. W. AMIDON, M.D.

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SOME RECENT CONTRIBUTIONS TO THE STUDY OF TYPHLITIS AND PERITYPHLITIS.

Fitz (R. H.) on Appendicitis. — Analysis of seventy-two cases seen in the last four years leads to the following conclusions:

1. Many cases of appendicitis are so mild as not to demand medical treatment. Although one third of all post-mortem examinations may show lesions indicative of an appendicitis at some period of the patient's life, the clinical history will frequently be negative.

2. A personal experience, if sufficiently large, is likely to afford conclusions which may have a greater value than those derived from a much larger number of selected cases. In Dr. Bridge's paper it was stated that four fifths of the patients were males. In my personal experience there are only twice as many males as females. The diagnostic value of sex is then distinctly less than the collective experience claimed.

3. In general the diagnosis of appendicitis is easy. It is based upon a localized tenderness, and the exclusion of all causes for such tenderness but the appendix. Still it has been my misfortune to make a diagnosis of appendicitis when it did not exist, and to fail in recognizing its presence until after death in a patient upon whom laparotomy was performed for the relief of a supposed acute mechanical intestinal obstruction. The following are the cases in which appendicitis was supposed to be present: A circumscribed peritonitis was recognized in the right lumbar and iliac region, and from its seat, sudden origin, and rapid progress was thought to be due to an appendicitis. The cavity was successfully drained, but the patient died of acute pneumonia in the course of a fortnight. The peritonitis had originated from an abscess in the liver, and this was attributed to a catarrhal colitis of long standing. In a second case of erroneous diagnosis there was a spreading peritonitis of the lower abdomen of sudden onset. The abdomen was opened and drained, but the appendix was found to be free from disease. After death the peritonitis was found to have resulted from a suppurating sub-peritoneal inguinal lymph-gland, the result of a gonorrhœa. Information concerning the latter disease was withheld until after the autopsy.

A third case gave such a misleading history that a pyosalpinx was mistaken for an appendicitis. The tubes were removed and the patient cured.

Lastly, a girl of ten years, suffering from a sudden and spreading hypogastric peritonitis, with a deep-seated tumor below the navel, was seen with Dr. Homans. Although some doubt was entertained as to the appendicular source of the disturbance a laparotomy was considered urgent. Dr. Homans successfully removed an ovarian cystoma, the pedicle of which had become recently twisted and its vessels strangulated.

4. Recurrence proved to be much more frequent than was found in the collective experience: 44 per cent. in my cases against 11 per cent. in the larger series. It is interesting to note that the frequency of the recurrence was about the same in those cases which were subsequently treated medically as in those which were oper-

ated upon. So far as this evidence goes, a recurrent attack makes no more urgent a demand for surgical treatment than does an original attack.

5. With regard to the duration of the disease, it may be said that although more cases recovered during the first three weeks under purely medical than under surgical treatment, this fact must be attributed to their mildness. Of the severe cases quite as many demanded from four to eight weeks for complete recovery, whether the treatment was medical or surgical. It cannot be claimed therefore for the surgical treatment of appendicitis that it has shortened the period of recovery. At least such a claim would not be justified by the results found in the cases which have come under my observation.

6. The rate of mortality in appendicitis is by no means clearly established. The physician who sees chiefly the mild cases says that it is very low, while the surgeon who is called upon for aid in the gravest cases considers the mortality to be very high. So far as I am aware, the cases observed by me form the largest number reported in the experience of a single individual, and they may be considered as establishing, for the present, the rate of mortality. Of these cases 74 per cent. recovered and 26 per cent. died. About one half of them were treated medically, the other half receiving surgical treatment. Among those treated surgically 40 per cent. died, while of those under medical treatment 11 per cent. died.

The spontaneous evacuation of pus, an event to be anticipated and guarded against, took place in 7 per cent. Of the cases treated medically 11 per cent. died, and in 14 per cent. there was spontaneous evacuation of pus, thus in one fourth of these cases the treatment should have been surgical. Since these medical cases were about half of the whole number seen, it follows that the treatment should have been surgical in about five eighths of the cases. The percentage of the cases ending in resolution was 36, which is practically the same as previously found.

It is evidently desirable to make the rules for the surgical treatment of appendicitis as simple as possible. I would advise surgical treatment for urgent symptoms, rising pulse and temperature, increasing distension and spreading pain with or without a tumor, and for a tumor with or without urgent symptoms. Recurrent attacks should be treated as first attacks. If recurrence is so frequent as to debar the patient from the enjoyment of life or the ability to earn, removal of the appendix between the attacks should be advocated.—*Boston Med. and Surg. Jour.*, June 19, 1890.

Homans (John) on a Case of Perityphlitis.—A. B. was a large, stout man of great physical strength and vigorous appetite, who led an exceptionally active and busy life. Some fourteen years before his death he was seized with a violent pain in the right iliac region, accompanied with some diarrhœa and the presence of a small, hard, painful swelling, situated on a level with, but towards, the umbilicus from the right anterior superior spine of the ilium. Owing to the extreme deposit of fat on the abdominal walls it was difficult to ascertain the exact size of the tumor, which, however, seemed to be about as large as the palm of a boy's hand, with a sharp upper outline, and impressed the observer as being a sort of cake of inflammatory material. There was little or no fever; the acute pain lasted some five or six days and then gradually subsided, the swelling gradually disappearing as the pain grew less.

From this time on the patient had several attacks, some five or six in number, of the same nature, save that they grew more severe, and the inflammatory cake increased in size till, in the last attack in which I observed him, it extended nearly to the umbilicus, and seemed to run under the edge of the floating ribs, the well-defined outline before described no longer existing. Whether this cake persisted in the intervals of the attacks it was impossible to say, but the patient suffered occasionally from diarrhœa, which would last a few days and was always accompanied by pain in the right groin.

His final illness was a most severe attack of jaundice, the discoloration and itching of the skin being extreme, and the mental depression, languor, headache, and all the other well-known cholæmic symptoms were present in a marked degree.

The autopsy showed nothing remarkable save the results of the intense cholæmic condition till the abdominal cavity was opened. The omentum was rolled and adherent to the border of the liver at the fissure of the gall-bladder; on the right

side over the region of the caput coli the peritoneum of the anterior abdominal wall was thickened and rough and a portion of the omentum still adherent, the result of former inflammation. Around the caput coli and ileum were numerous old adhesions and bands, and the appendix was concealed from view by the mass of old inflammatory structures. It did not present any appearance of ulceration or perforation.

The stomach was drawn up close under the liver, and the tissues surrounding the common bile duct from beginning to end were greatly increased. They presented themselves as a mass measuring over two inches in cross-section. A considerable portion of this mass was composed of fat and several lymphatic glands held in very dense connective tissues, much finer than usual in this situation. The opening of the common bile duct on the surface of the duodenum could be detected, and was not eroded or ulcerated. A probe passed up the common duct entered easily into the hepatic duct and into the liver, but could not be made to enter the cystic duct. The gall-bladder was found in the midst of the adherent omentum, and presented itself as a yellowish-white body of less circumference than the little finger, one and a half inches in length, the fundus being about two inches from the border of the liver; on section a fluid ran. Cavity contained about twenty gall-stones, one the size of a small pea, but mostly about the size of the head of an old-fashioned brass pin. These were imbedded in a yellowish gelatinous mucus. Probe passed from the gall-bladder through the cystic duct failed to enter, and dissection showed that the duct was closed and converted into a fibrous cord. The liver in section presented a pretty uniform appearance save for some slight evidence of fatty degeneration. The interacinous connective tissue was not increased. The portal veins were normal. The other abdominal organs presented nothing remarkable.

It is interesting to consider whether the result of this case would have been different if the operation recommended by Treves had been performed, and the appendix removed in the interval of the attacks. Against Treves' operation, in any case, I think there are two strong arguments, the first of which applies with equal force to Tait's procedure of catherizing the appendix, and pressing back the foreign body, if any exist, into the cæcum. These arguments are: first, the difficulty of finding the appendix; second, a doubt whether the mere removal of the appendix will insure cessation of the attacks.

It is by no means an easy thing to find the appendix in a fulminating case when the adhesions are recent, and easily broken down, and the anatomical relation of the parts are not much disturbed. But in this case, for instance, with the old tough adhesion masking the site of the operation, the surgical procedure would have been more or less blind, and the discovery of the appendix almost more a matter of chance than of skill, involving an amount of handling and general turning over of the intestines which would materially have affected the chances of recovery. It should be borne in mind, also, that the appendix is frequently found in abnormal situations by surgeons who are operating during a first attack. Thus it has been found near the umbilicus. I have discovered it on autopsy hanging down in the pelvis bathed in pus, and nearly touching the rectum; and Dr. G. H. Monks in a recently reported case removed the appendix from a tumor of the scrotum.

Granting, however, that the appendix has been successfully removed, or its calibre occluded by stitching, as Tait recommends, can a positive assurance of freedom from further attacks be given? This question must, I think, be answered at present in the negative. In Treves' and Tait's cases sufficient time has not yet elapsed to make them of any value. In such as the cases above described, Treves' or any operation would have to be done early to be of any especial advantage, and at this time patients would not be apt to present themselves, while after three or four attacks the amount of inflammatory structures would be so great, and the innervation of the organs so affected, that the mere removal of the appendix would not be sufficient to stop the trouble. If then a patient recovers from one or two attacks under medical treatment, and then seeks relief through surgical aid, there is strong probability that the operator by not finding the appendix in its normal surroundings, may subject his patient to an operation dangerous because of its length, and the resulting shock, which operation would not promise any immunity from the dis-

ease.—*Boston Med. and Surg. Jour.*, July 24, 1890.

Gerster (A. G.) on Appendicitis and Perityphlitic Abscess.—It is the author's wish to finally maintain the importance of the principle that every intraperitoneal abscess should, if possible, be opened and drained without invading the normal peritoneal cavity—that is, through existing planes of adhesion to the parietes. With few exceptions, all perityphilitic abscesses have such an approachable side. To study to ascertain and to utilize them is the duty of the conscientious surgeon. It is idle to state that incising and draining an abscess through a laparotomy wound, —that is, through the free peritoneal cavity —is an easy or indifferent matter. No competent person will believe it.

1. Ilio-Inguinal Type (Willard Parker's Abscess). The normal situation of the caput coli and appendix vermiformis near the parietes of the right iliac fossa has the consequence that the great majority of circum-appendicular abscesses will naturally establish themselves so as to have for one of their limiting walls the parietal peritoneum of that region. This has led to the erroneous belief that perityphlitic abscess is nominally situated behind the peritoneal lining of the iliac fossa. This situation involves the great practical advantage that the abscess can be permitted to assume certain proportions so as to render its incision simple and free from the danger of invading the normal peritoneal cavity. Therefore when an immovable tumor develops in the right iliac fossa soon after the inception of the malady, it is safe to wait a few days until the abscess has assumed a certain size. On the fourth, fifth, or sixth day it may safely be incised. Searching for pus with a hollow needle is superfluous when the abscess is superficial, that is, immediately beneath the parietes; dangerous if it is deep-seated, as the gut might then be injured or the healthy peritoneum infected. The only safe way of opening these abscesses is by methodical and careful dissection, layer by layer being divided by an ample incision through the longer axis of the tumor. The vicinity of pus will become manifest by the discoloration and condensation of the tissues. When the abscess is opened and the bulk of its contents has escaped, a gentle exploration by the index finger is advisable to detect recesses or a foreign body. But all rough treatment of the walls of the cavity by scraping, tearing, or rude squeezing is reprehensible, as it may lead to inward rupture. For the same reason search for and removal of the ulcerated or necrosed appendix from the abscess is to be avoided as unnecessary and dangerous. Two drainage tubes are slipped into the cavity and fastened in the usual manner. They will facilitate irrigation without causing undue distention. A daily change of dressings will be required for the first week or ten days. As soon as the discharge becomes scanty and serous, the tube should be removed.

The ilio-inguinal is undoubtedly and fortunately the most common form of perityphlitic abscess, and its time-honored therapy, as laid down by Parker, will have to be retained as safe and successful.

2. Anterior Parietal Type. Next in frequency to the ilio-inguinal form is the type according to which the bulk of the purulent collection is found immediately behind the anterior abdominal parietes of the right side. Frequently this is associated with a more or less apparent ilio-inguinal tumor, and might be looked upon as its extension. The swelling is generally found behind the right rectus muscle, its shape vertically elongated, its upper limit occasionally extending beyond the level of the navel to the hypochondrium its proximal margin to or beyond the median line. When an unmistakable continuation of the tumor can be traced into the iliac fossa, the abscess can be safely opened above Poupart's ligament, as in the preceding group. But occasionally the upper extension will require a separate incision. When it is found that the iliac fossa is normal and entirely void of resistance, and a circumscribed tumor can be clearly felt some distance from the ilium and Poupart's ligament, it is necessary to ascertain where to make a safe incision. If the extent of the tumor is great, a direct incision may confidently be made. But if the superficial extremity of the tumor is small, it will be safer first to open the peritoneal cavity in the median line by a small incision, and digitally explore the exact relations and extent of the adhesion. Having thus located the abscess, the exploratory cut is closed, and the abscess is incised by a direct route.

3. Posterior Parietal Type. Whenever perforative processes occur in the appendix,

located near the posterior parietes of the peritoneal cavity—for instance, near the right sacro-iliac synchondrosis or the lumbar region,—the resulting abscess will naturally have a deep situation. Cases will occur in which incisions of such an abscess cannot be made unless it be done through a laparotomy wound. But there can be no doubt that, in a certain proportion of these cases, a safe incision may be made from behind.

4. Rectal Type. It is a good rule never to neglect to examine the rectum of a patient suffering from perforative appendicitis. A long appendix may become fixed and perforated in the small pelvis, and an abscess is then apt to develop in close vicinity to the rectum, whence it can be safely opened and evacuated. The objection that fæces might enter the abscess has not thus far been verified by experience.

5. Mesocœliac Type. To characterize that most serious type of circum-appendicular abscess the walls of which are composed entirely of agglutinated intestines, and which hold no immediate relation whatever with the abdominal parietes, the term mesocœliac was chosen. The abscess is found occupying, as it were, the middle of the peritoneal sac. Hence, to reach and evacuate this form of abscess, the free peritoneal cavity must be opened, and the collection of pus must be reached by separating the adherent coils of gut which enclose it. We owe the development of the *technique* of the evacuation of these abscesses mainly to McBurney, whose procedure is as follows: A longitudinal incision, as for simple appendicitis, is made parallel to and along the outer border of the right rectus muscle. The abnormal cohesion and resistance of the implicated intestines will point out the site of the abscess. The protruding normal coils of gut should be packed away under a protective bulwark of sponges held *in situ* by the assistant's hands, so that, if abscess is opened unawares, no pus shall soil the healthy peritoneum. Two of the nearest coils are now gently and cautiously separated by gradual traction, exercised by the operator's fingers, until a small quantity of pus is seen exuding. It is desirable to let the pus escape slowly so as to have ample time to sponge it away as it pours out, otherwise the whole field might be overwhelmed and contaminated by a sudden flood of matter. (It seems that exhausting the abscess through a small aperture by means of a syringe would be an improvement upon the mopping up with sponges.) As soon as the bulk of the pus has been removed, the cavity is wiped out clean with sponges dipped in an antiseptic solution, and now the adherent intestines are still more separated to permit the surgeon to inspect its interior. If the appendix is loose and easily to be got at, it can be removed, but if it is found closely adherent and very brittle it is better to remove only so much of it as will come away easily. A good-sized drainage-tube is placed into the bottom of the cavity, which, in addition, is loosely packed with iodoform gauze. This and the rubber tube are brought out near the lower angle of the wound, and the abdominal incision is closed in the usual manner. If the case is progressing well, the packing can be withdrawn on the third day, as by that time protective adhesions will have formed between the adjoining coils of gut. The drainage tube is to be removed as soon as the secretions become serous and scanty.

Recurrence of suppuration in the groin, following spontaneous or artificial evacuation of a perityphlitic abscess, may be due either to the persistence of a small fæcal fistula or to the presence of secondary intraparietal sinuses caused by inadequate drainage and retention. In the first case prolonged and efficient drainage is to be employed for a long time before resorting to artificial closure of the fæcal fissure by laparotomy and enterorrhaphy or otherwise. In the second case all sinuses and pockets have to be found by free and careful dissection, and when they have been slit up and scraped, the wound is to be treated by the open method to effect a sound cure.—*N. Y. Med. Jour.*, July 5, 1890.

Foxwell (A.) on Typhlitis.—For the correct understanding of the disease peculiar to the right iliac fossa an accurate knowledge of the anatomy of the cæcum and appendix is necessary. In the fœtus, the three longitudinal muscle bands of the cæcum are equidistant from each other, and at their point of juncture the appendix arises. In 90 per cent. of the 100 adult cæca examined by Treves, he found that the portion of the cæcum to the right of the anterior band grew out of all proportion to the rest, and beside this that the anterior surface of the cæcum grew more than the

posterior; hence the point of junction of the bands, that is, the point of origin of the appendix, comes to occupy a position on the inner posterior aspect of the cæcum, near the ileo-cæcal valve, while the hypertrophy of the externo-anterior portion causes this to form a new apex of the cæcum.

What is the cæcum? Where the ileum opens into the colon this latter has a blind offshoot or bag, which in man is smaller in size than in the lower animals, and its distal two-thirds is converted into a blind tube some four inches long and a quarter of an inch in transverse diameter. The proximal one-third appears like a bloated blind end or *backwater* of the ascending colon. I have noticed in post-mortem examinations that usually, when the cæcum is dilated, it revolves to the left on its vertical axis, and also tilts its blind end upwards, so that its new anterior surface is formed by the original antero-external and by a portion of the blind end. This mobility and revolution explain without doubt the frequency with which the cæcum is found adherent to the anterior abdominal wall and induces inflammation in this.

Fæcal accumulation is the commonest cause of typhlitis, whether originating in the cæcum or in the appendix. The reasons for the lagging of fæces are:

First, in the horizontal position the cæcum acts as a backwater to the ileo-colic river, and the more solid portions, as well as the flotsam and jetsam of the stream, naturally lag behind in its eddies and adhere to its sides; while in the upright attitude it acts as an intestinal catch-pit for all the heavy matter.

Secondly, the propinquity of its longitudinal bands lessens greatly its power of forcing its contents into the colon, as they leave more than half the circumference on the antero-external side entirely deprived of longitudinal expulsive force. That this is a factor to be considered is evident from the examination of the cæca in healthy abdomens, where this portion is generally found to be more or less dilated and bulging out from the restraint of the anterior and posterior bands, if there be any gaseous distention of the gut.

Thirdly, the carrying power of a stream varies inversely as its sectional area, other things being equal. The sectional area of the cæcum is considerably larger than that of the colon and nearly double that of the ileum. Materials, therefore, which are easily swept along by the ileum will become deposited in the bands of the cæcum, especially since it is an intestinal backwater, and so out of the way of the full mid-stream current.

Fourthly, water is largely absorbed from its surface. The longer materials reside in it, therefore, the less likely are they to be driven, but they gradually dry and adhere to its lining. The effect of this absorption is largely increased by constipation.

Fifthly, its very mobility helps the stagnation of its contents, for it is like a bladder fixed to the end of a rigid tube; and such a condition is more likely to bring about a kink than if the combination were equally rigid or equally mobile.

Sixthly, the ileo-cæcal valve helps cæcal obstruction. It is so fashioned that the fuller the cæcum, the more closed the valve becomes, and therefore the more the overladen cæcum requires cleansing, the less will be the force of the cleansing stream.—*Birmingham Med. Review*, July, 1890.

GERTRUDE B. KELLY, M.D.

REPORT ON OBSTETRICS AND DISEASES OF CHILDREN.

BY ELIZABETH STOW BROWN, M.D.

Hirst (Barton Cooke) on Detachment and Expulsion of the Vaginal Portion of the Cervix during Labor.—The patient was thirty-four years old and had had five children. Her labors had all been difficult and, with one exception, instrumental, partly on account of a slightly contracted pelvis, but mainly because of unusually large children.

Labor began by rupture of the membranes, and rigorous uterine contractions soon followed. The os dilated unevenly, the anterior lip, nipped between the head and symphysis, remained thick, firm, and unyielding, but was not œdematous. After more than twelve hours of ineffectual uterine and abdominal contraction, a fleshy mass was discovered protruding from the vagina; it proved to be the vaginal portion of the cervix, lacking a small piece posteriorly. The head was found well down in the pelvis, and the child was extracted by forceps. Twenty-four hours after labor a vaginal examination was made. No trace of a

cervix could be felt except posteriorly, where a tongue of cervical tissue projected into the vagina. There was no hemorrhage during labor or afterward, and the puerperium has been uncomplicated except for a slight cystitis. At the time of writing, three weeks *post partum*, the tongue of cervical tissue projects from the median line posteriorly, the entrance to the uterus is reduced to its ordinary calibre by cicatricial puckering in the centre of the vaginal vault, and the involution of the uterus has progressed normally. The dilatation of the os was, no doubt, prevented in this case by cicatricial infiltration, the result of injuries in former labors.—*Medical News*, June 14, 1890.

Wood (William B.) on the After-Treatment of Obstetric Cases.—The author some years ago became convinced from various series of observations and tests, that the number of cases of confinement in which the cervix was torn was really greater than any published average. He believes that slight lacerations at least occur in every confinement. For five years he has worked upon the theory that if the minor lacerations, which are to be found immediately after labor, are so kindly and rapidly healed, the more serious ones would also heal if the wounds could be kept long enough in conditions favorable to such repair.

The first requisite of a successful treatment, according to the writer's opinion, is to keep the uterus well up until involution and healing are complete. After confinement it is recommended to keep the patient in bed *four weeks*. The recumbent position should be kept for from fourteen to twenty-one days. At the end of that time an examination with Sims' or the genu-pectoral position should be made. From this time on, hot injections, given after Dr. Emmet's method, may often be used to advantage, but should not be employed when there are entensive lacerations, as the hot water in long injections renders more difficult the union of the surfaces. These torn surfaces will sometimes unite as late as the fifth week, provided the recumbent position be so long maintained. If at the end of the fourth week the condition of the cervix is satisfactory, the patient may safely be allowed to get up; but never on any condition without first having the still heavy uterus supported by well-adjusted pads. In from five to eight weeks after confinement the uterus will, in favorable cases, with this assistance, have returned to its normal condition, and will remain in natural position without artificial support. The physician is advised to examine the patient once a month for a year after confinement, to assure himself that no displacement has been brought about by accidental causes. "Many maintain," so says the author, "that women will not be at so much trouble. But in my experience there are few women who will not cheerfully submit to any course of treatment that obviates the necessity for an operation."

The favorable reflex influence that nursing has upon the pelvic organs is an important element in stimulating them to return to normal conditions. But when the nursing becomes a drain upon the mother, this stimulation ceases.—*N. Y. Med. Jour.*, Aug. 2, 1890.

Price (Joseph) on Early Operations in Purulent Peritonitis.—The author states that "no case of general puerperal peritonitis will recover without operation." When there are simple inflammatory signs without localized mischief, which is the focus of the general trouble, recovery will follow general treatment. If there is pus in these cases, the necessity for early operation is as much to be recognized as in any other case or set of cases in abdominal surgery. There is but one treatment for suppurative peritonitis—section, irrigation, and drainage.

Postponement is more dangerous than the operation, and at the most only hastens a result which is bound to follow without operation.

The writer cites the histories of five cases where operative measures in puerperal peritonitis were successful. He notes that these cases were all true puerperal "fever"; all were saved by section, after well-directed medical treatment; and that the operations were undertaken to save life, not to demonstrate ideal surgical procedures.—*Medical News*, Aug. 9, 1890.

Porro-Cæsarean Operation.—Dr. J. F. Baldwin (*Medical Press*, Aug. 9, 1890) publishes the history of a successful Porro-Cæsarean section in the case of a typically rachitic dwarf. The pelvis was uniformly contracted, with an antero-posterior diameter of about one and one quarter inches. The patient was twenty-four years old, weight, 100 pounds; height, 47½ inches. The patient was seen one week before term, and it was decided to operate as soon as labor

began. The operation was commenced when the os was dilated to about the size of a twenty-five cent piece. The method of Tait was followed. Five assistants were employed. The abdominal incision was just long enough to introduce the hand. A small incision was made in the uterus and enlarged by the two index fingers to the full extent of the abdominal incision. A leg of the child was grasped and it was thus delivered. The cord was at the same time seized with compression forceps and cut. The placenta was then extracted through the wound, the uterus lifted out of the abdomen, the rubber tube tightened and secured by a second hitch, the cervix transfixed by knitting needles in the form of a St. Andrew's cross, and the body of the uterus with the ovaries and tubes cut off. Convalescence was prompt and unmarked by any special occurrence. Lactation was normal. The child was a female, and weighed at birth seven and one half pounds. Although inheriting the peculiar deformity of the mother, it thrived very well until the age of nine months, when it become affected with angina Ludovici, of which it died two days later.

The writer attributes the fortunate result in this case to the promptness with which operative procedures were instituted. Tait is a strong advocate of the Porro-Cæsarean section. He says it is as easy as the application of long forceps, and hence should be selected by operators not familiar with abdominal work.

Dr. W. Cadge (*Br. Med. Jour.*, July 19, 1890) reports a case similar to the above. The patient was a rachitic dwarf, 46½ inches tall, with a hydrocephalic head, 24 inches in diameter. The antero-posterior diameter of the pelvis was an inch and a half. The fœtus was extracted by the head. The uterus and its appendages were removed. The child was cyanosed at birth, though it cried well and seemed to recover. But the breathing did not become normal, the cyanosis increased, and it died four hours after birth. The patient, during puerperium, had an attack of acute pleurisy on both sides, from which, however, she recovered, though imperfectly.

Crothers (T. D.) on Alcoholic Heredity in Diseases of Children.—In the study of the early history of inebriates, a great variety of diseases common to childhood appear, and seem to have been more intense than in other children. Such cases seem to have suffered more severely than others from nutrient disorders, shocks, and traumatism; they are freighted with some heredity or predisposition to particular forms of degeneration; the organism has received a certain bias from which it cannot escape. Alcohol, of all drugs, seems most potent to impress cell growth and function.

It is an established fact that alcoholic ancestors will transmit to their children a defective brain and nerve power. The form and shape of this defect will vary widely in their manifestations. In many cases the defect will not be prominent until after the higher peripheral brain has reached a certain development, especially in the growth of the emotional and inhibitory centres. In others this defect is seen in infancy, in an abnormal hyperæsthesia of the senses and nutrient disturbances. Some children show low powers of vitality and slow, irregular growth. This condition may continue for years, then gradually disappear, and only reappear at puberty, or later, in some distinct form of degeneration. Sometimes a marked neurasthenia and anæmia appear in early life and continue to puberty, then to develop into some chronic disease. Another class of children are noted who come from alcoholic ancestors by their precocious development of brain and nerve force. Inebriety, insanity, or both are very common sequels. Alcohol or opium in any form is almost always a grateful remedy. In some children the craving for spirits is manifest very early; but the abnormal tastes of children, and their extreme sensitiveness or obtuseness of sensory impressions, and low powers of vitality and recuperation are often clear symptoms of an alcoholic impression from ancestors. This alcoholic heredity will be seen in children that manifest extremes of activity, particularly where there is a tendency to the sudden liberation of nerve energies, as in violent passion, or work, play, or study, which is followed by extreme prostration. The child is said to be sullen, morose, or melancholy, then suddenly manifests the other extremes, indicating a great instability of brain cells and functional control. The child's life seems to be threatened with fevers, prostrations, and inanitions, accompanied with mental irritations and wandering neuralgias, that tax severely the skill of the physician. These conditions may follow other heredi-

ties, but they always point to a degree of nerve and brain degeneration or retarded development, and defective co-ordination, that must be recognized in treatment.

From the facts it will be obvious that the diseases of children of alcoholic parentage are far more complex, and require greater care; for in addition to whatever disease they suffer from, there is always neurasthenia and defective control of brain centres.

The general principles of treatment recommended are:

1. No form of alcohol is safe, and narcotics of all kinds should be used with great care.

2. The diet should not include meats of any kind, because of their stimulating character.

3. The general hygiene should be most carefully attended to.

4. Cases of this sort should be guarded against every possible extreme.

Recent studies of alcoholism show that over 70 per cent. are directly inherited. If this is confirmed by later studies, the treatment of inebriety will in the future begin in infancy.—*Am. Lancet*, June, 1890.

Thomson (Hugh) on Inoculation, with Suggestions for its Further Application in Medicine, Especially in Mitigating the Severity of Measles.—Three years ago the author published a paper on "Inoculation," wherein he endeavored to show that the reason why the virus of small-pox inoculated into the skin gave rise to a milder attack of the disease than when it was introduced by infection—that is to say, by the air inhaled by the lungs,—was, that "by implanting the microbes of the virus in a part well suited for their development, and that a non-vital part, we create a local disease which spoils the blood of the persons inoculated as a suitable medium for the cultivation of the microbe, and consequently of giving rise to a general disease; that, from the descriptions of inoculated small-pox given by the most successful inoculators, an early and extensive development of the disease in the inoculated part foretold a mild attack of general disease with a favorable issue, whilst a late and scanty local effect prognosticated opposite results; that, thus, the order of evolution of the disease was reversed, the skin being the first attacked and the blood the last, instead of the blood being the first and the skin the last. In this way we avert the danger of inflammation of internal vital organs, for before the blood becomes affected so as to give rise to a general disease, it has been robbed of its susceptibility to undergo zymosis. I desire now to consider whether inoculation may not be employed with the object of mitigating the severity of other exanthematous and zymotic diseases, as measles and scarlatina."

The author records thirteen experiments, twelve of them being inoculations on young children with the virus of measles. He concludes that, while inoculation with blood is objectionable, it is more efficacious than the use of serum from a blister when the efflorescence is abundant. He believes inoculation to be the only way by which we can control and regulate the incidence of the disease, and that a systematic inoculation of the population should be carried out. A table is presented to show the mortality from measles in the eight principal towns of Scotland during each month from 1873 to 1881. It is shown that the mortality in March, April, May, and June was three times as great as it was in September or October; in July, nearly thrice; in February, twice; in January, nearly twice; and in December, nearly twice. In November, although a cold month, the mortality is not much over that of October.

From another table it is shown that the mortality from pertussis, bronchitis, and pneumonia is almost exactly in the same ratio for these months as that of measles, showing a close alliance between them. The prevalence of measles is not dependent upon season or weather, but the fatality of it is, to a large extent, dependent upon its association with diseases affecting the lungs and bronchial membrane, such as pertussis, bronchitis, and pneumonia. It would, therefore, be of importance to limit inoculation as much as possible to the months in which these diseases are least prevalent. These, judging from the mortality, are September and October.

As to the age at which inoculation ought to be done, it can scarcely be done too early. But, seeing that it is of importance to avoid pulmonary complications, the months of September and October first, after the child has attained its sixth month, might be chosen.

From the tables appended, it is seen that the greater proportion of attacks are in

children under the age at which school attendance begins. That a certain connection between school attendance and the spread of the disease however exists may be inferred from what was observed during an epidemic in the Staffordshire Potteries. When the schools were closed, the epidemic appeared to be arrested, but as soon as they opened again, it recommenced. The comparatively small number of children at school age attacked shows that the school children contract the disease at school, and convey it to their homes, when all who have not already had it are immediately attacked. This suggests to the writer that a good time for inoculating, until at least a more systematic method be adopted, would be whenever the disease was thus brought into a family. The first attacked would furnish matter for inoculating the rest. Under such circumstances there would be no objection to the proceeding, as all would inevitably be infected in a short time, and if it were necessary to employ blood for the purpose, it would be family blood.—*Glasgow Med. Jour.*, June, 1890.

Lydston (G. F.) on a Plea for Early Operative Interference in Acute Peritonitis in Children.—The author believes that many cases of peritonitis in children are due to perityphlitic inflammations, which are similar to those occurring in the adult, with the exception that in the child they are followed immediately by acute general peritonitis, while in the adult intermediary changes about the cæcum occur. In cases of traumatic origin, the site of the injury might escape observation, because of the rapidity with which ecchymosis had disappeared. The surgical treatment is the important consideration in connection with this disease. The author concludes that:

1. The profound prostration and cardiac inhibition characteristic of peritonitis are in a great measure incidental (1) to tension of the peritoneum, produced by inflammatory products, with a consequent reflex inhibition of the heart, and (2) to mechanical interference with the heart's action.

2. Surgical interference is indicated in all severe cases of general peritonitis, and in cases of localized suppurative inflammation, or in cases of perityphlitic origin, whether due to foreign bodies or not.

3. There is every indication present for operation, and no logical objection to it. The operation is almost invariably palliative, if not curative.

4. Operation in no sense impairs the chances of recovery. *Per contra*, it enhances them to a great degree.

5. No case should be allowed to die without operation, unless already *in articulo mortis*.

6. It is not necessary to make a large incision, excepting in cases in which perityphlitic abscess is known to exist, which is rarely the case with children. If perityphlitic abscess exist, and is recognized before operation, the incision should be made at the most favorable point, which, in the majority of cases, is the typical line for ligation of the common iliac, as pointed out by Murphy and Lee. In by far the majority of cases in children, a simple exploratory incision, with flushing of the abdominal cavity, is sufficient.—*Arch. of Ped.*, Aug., 1890.

REPORT ON DISEASES OF THE EAR AND EYE.

BY A. T. MUZZY, M.D.

Pitts (B.) on Trachoma.—This is a disease among the poorer classes of civilized countries. I have met with hardly a case among the negroes of the South, though in Missouri a few cases may be seen among that race. Their exemption is due to race peculiarity. Sattler claims a specific bacterium for the disease. Yet cases are constantly seen where only one eye is affected, the other remaining exempt wholly or for many years. Chronic inflammation of the eyes sooner or later have granulations appear. The progress is insidious, and slowly characterized by formation of yellowish and grayish bodies, accompanied by vascularity, roughness, and thickening of the conjunctiva. After long periods this changes to dense white tendinous scars, which in shrinking produce entropion. The cornea is quite generally affected during the progress of the disease. Treatment of this condition is most varied. In my hands the most successful line is expression of the diseased follicles by squeezing them with ring forceps, occasional use of the ointment of yellow oxide of mercury, and solid sulphate of copper. —*Am. Jour. Ophthal.*, April, 1890.

Naylor (A. G. E.) on a Case of Pulsating Tumor of the Orbit.—A woman, sixty years old, with very good family his-

tory, has had repeated attacks of epistaxis for the past fifteen years. The last three attacks under my observation have been arterial. After the second of these attacks, eighteen months ago, following retching, she perceived abnormal sounds in her head, and the right eye began to protrude, and vision became defective. Examination showed swelling of conjunctiva, lids, pulsation of the eyeballs, ptosis, and a well-marked bruit over the eye and the head. The ophthalmic vein and branches were distended, and a small pulsating tumor formed from the vein, with stained condition of skin. Orbital aneurism was diagnosed. A year later, two days after another epistaxis, the left eye, conjunctiva, and lids puffed excessively with exophthalmos, which condition still exists in a slightly modified degree. The engorgement of the ophthalmic vein and the extensive chemosis point to the passage of arterial blood from the cavernous sinus of one side through the circular sinus to the opposite cavernous sinus.—*Australian Med. Gaz.*, Feb., 1890.

Bennett (A. H.) and Savill (T.) on a Case of Permanent Deviation of the Eyes and Head, the Result of a Lesion Limited to the Sixth Nucleus; with Remarks on Associated Lateral Movements of the Eyeballs, and Rotation of the Head and Neck.—The first phase of the case was paralysis of the left upper extremity, suddenly losing during the night all power from the shoulders downwards. There was no wasting nor loss of sensibility, and some weeks later there was exaggerated tendon reflexes. With this there was associated a very slight paresis of the left side of the face, but the left leg not perceptibly. At no time were convulsions noted; intelligence was not seriously impaired, and the other organs and functions of the body were normal. This condition remained unchanged until death, three months later. Diagnosis made during life was interruption of the pyramidal tract between the cortex of the ascending frontal and parietal convolutions, and the upper part of the internal capsule on the right side, slightly encroaching on the facial area. The post-mortem showed this surmise to be correct. The second phase of the case is equally definite, and while being very rare in occurrence, is very interesting as demonstrating some very important physiological facts. About a month before her death, she awoke one morning with her eyeballs, head, and neck firmly rotated to the right side, and no voluntary effort of her own could bring them, especially the left eye, beyond the middle line. There was marked stiffness and contraction of the left sterno-mastoid muscle. The two eyes in conjunction could not be moved towards the left, but the right eye would converge, as when the two eyes were fixed upon an object that was brought close to. That is, there was complete conjugate paralysis of the eyeballs on the left side. The deviation of these to the right being due to the unopposed action of the healthy muscles of that side, convergent action of the two eyes being also intact. These symptoms in no way improved, but remained permanently unchanged. The post-mortem showed that the diagnosis of lesion of the left sixth nucleus was a correct one.—*Brain*, July, 1889.

Dunn (J.) on a Case of Reflex Amblyopia Cured by Section of the Supra-Orbital Nerve.—A student aged nineteen was struck over the right eye by a snowball in the winter of 1886, which caused intense pain for a time. In the spring of 1887 was subject to considerable neuralgia about the eyes. And in June sight began to fail, the trouble increasing, though under treatment to October of 1889. In October the following was the condition: nictitation of right lower lid very severe and occurring twelve to fifteen times a minute. This nictitation commenced soon after injury and has continued ever since. There is no corresponding action of the left lower lid, though both eyes show an irritable hyperæmic condition. The cornea, aqueous, lens, iris, and vitreous normal, with tension +. Both eyes are always painful, though varying in degree at different times. The patient also complains of a gray cloud, which made its appearance a year ago and is subject to the same variations as the pain. Muscular equilibrium undisturbed. V right, $\frac{8}{200}$; left, $\frac{18}{10}$, accepts no glass. Under atrophine, right, $\frac{8}{200}$; left, $\frac{18}{100}$, with improvement for left only with + 48″ to $\frac{18}{10}$. Field of view, as tested by perimeter, very much contracted, especially the right. General health has always been good. There was a family history of failure in vision, so that patient attributed his condition to heredity. No change had been obtained under various lines of treatment.

April 12, 1890, in passing my finger over supra-orbital notch, the twitchings were increased in frequency and strength. This led to section subcutaneously of the supra-orbital nerve, the point of a small knife being forced to the bone external to the nerve and swept across the notch. The section of the nerve was perceptible. Improvement was immediate, pain on closure of lids disappearing, and pressure over notch no longer producing spasms of lower lid. April 15th, V right, $\frac{20}{100}$; left, $\frac{18}{40}$. May 2d, V right, $\frac{18}{40}$; left, $\frac{18}{15}$. May 8th, V right, $\frac{18}{15}$; left, $\frac{18}{15}$. All pain and nictitation have disappeared; the field of view is nearly normal, and study for two hours has not been followed by any discomfort.—*N. Y. Med. Four.*, Aug. 9, 1890.

Gill (J. W.) on Transient Recurrent Attacks of Lateral Hemianopsia.—A healthy, well-nourished man, aged sixty-five years, states that he has had these attacks since he was twenty years old. The first occurred as he was returning from work as miner underground. He noticed that he saw only half or part of any thing looked at; half of a man's face, one of two objects close together. With this was a sense of great anxiety beyond that due to the condition of his sight. Also a fulness of the epigastrium, as of "wind on the stomach." After a few minutes vibratory oscillations of light occurred over the obscured part of the field of view, the vibrations increasing and finally diminishing their intensity for fifteen minutes, when the vision became normal. This was followed by slight headache. He has these attacks sometimes with intervals of a few days, sometimes of a number of months, and varying in duration from a few minutes to an hour. Of late years the condition has seemed to him to be subsiding. There is no history of nervous complaint, or phthisis. For the past nine months he has lost the sight of the left eye from acute glaucoma. The right is sound.

A second case with attacks identical is that of a student, where the first attack was not repeated for four years, then reappearing at intervals of a few days.—*Brit. Med. Four.*, Feb. 1, 1890.

Tiffany (F. B.) on Blindness from Quinine or Quinine Amaurosis.—A lawyer, thirty-four years old, of good general health, who uses tobacco and liquors sparingly, and who has been accustomed to take quinine in small doses, which produced prompt and full physiological effect, was ordered by his physician five grains of quinine every three hours for a slight attack of influenza. From 8 P.M. to 4 A.M. he took six. At this time he told time by the watch all right. From this time until morning slept. When he awoke he found he was totally blind. Can only see a halo of light with a spot in the centre size of a silver dime. Examination shows pupils dilated ad maximum, do not respond to light; he cannot recognize even pencils of bright light. The optic nerve and retina are blanched and anæmic. Catharsis was ordered and a half-per-cent. solution of eserine locally every two hours. Besides inhalations of sulphuric ether were instituted and the recumbent position. After one day esserine was instilled twice a day. In three days inhalations of nitrite of amyl were substituted for the ether. Gradually tension of the globes returned to normal, the engorged veins subsided, and from recognition, the fourth day, of bright flashes of light sight has improved so that in twenty-five days he could see nearly normal—right, $\frac{20}{15}$; left, $\frac{20}{30}$—though the field was contracted. The treatment, as it seems to me from my observations and research, is the recumbent position and use of stimulants as nitrite of amyl, strychnia, and electricity. *Denver Med. Times*, June, 1890.

Salzer on Trephining for Abscess in the Brain.—A child, aged eleven years, who had complained for several years of a discharge from the ears, in February was attacked with severe symptoms of brain trouble, vomiting, fever, paresis, and spasm of the right side of the body, with fetid odor from the left ear. These symptoms increasing, the left mastoid process was trephined and a necrosed portion of dura mater removed. No pus was found under this, but from the sigmoid sinus flowed an offensive fluid. The sinus was freely opened and treated as an open wound, healing very quickly. During recovery the patient had the feeling of falling out of bed, and later of giddiness, always falling towards the left. This symptom may be due to a lesion of the vault, though Prof. Politzer would ascribe it to a serous effusion under the dura mater.—*Med. Press*, July 2, 1890.

Tiffany (F. B.) on Total Deafness from Quinine.—To understand the pathological condition and appreciate how an over-supply or even a common supply of

blood to the internal ear may disturb its functions or obliterate them, it is well to recall the bony walls of the vestibule, cochlea, and semicircular canals, and the minute canals by which the nerves of hearing enter those minute cavities from the brain. The case presented is that of a boy of six who is totally deaf. One year and a quarter ago the child was unconscious for fifty-three days, the attending physician diagnosing malarial fever, and using very large doses of quinine. After two months the child got up, but staggered in his gait, this lasting all summer, and for six months could not walk straight. He had not heard anything since getting up. Examination showed no abnormality in the ears or nasopharynx. Nor was there any history of such trouble. I believe the lesion in this case is one of the auditory nerves in the labyrinth. From the disturbance of equilibrium we are inclined to limit it further to the semicircular canals.—*St. Joseph Med. Herald*, July, 1890.

Sexton (S.) on Operation for Deafness and Tinnitus Due to Immobilization of the Ossicles, and for Otorrhœa.—With the aid of the electric head-light and illuminating and magnifying lenses one can now examine the ear as minutely and operate upon the delicate parts with the same safety as elsewhere. Ordinary treatment has been proved useless in a large number of cases of purulency with old pus sinuses into the attic. It is in these that the new appliances are valuable. I remove the remains of the drumhead and the diseased anvil and hammer, after loosening their attachments, and separating the incus from the stapes. There is rarely any hemorrhage where the granulation tissue has previously been reduced. The principal results are arrest of purulency and often a marked improvement in hearing. Operation for sclerosing aural catarrh does not vary much from the above. Cases indicating operative treatment are (1) when ordinary conversation is not heard close by, or a loud tone three feet away; (2) when there exists with the deafness distressing tinnitus. The results for three years are very gratifying.—*Brit. Med. Jour.*, Jan. 11, 1890.

Bronner (A.) on Massage of the Membrana Tympani and the Ossicula in the Treatment of Chronic Catarrh of the Middle Ear.—Otologists have certainly tried all conceivable remedies for this very common affection: they have blown air through the Eustachian canal with Politzer's bag or with addition of the catheter; they have blown all kinds of vapors and fumes; injected many liquids; have passed bougies; used electrolysis, and electricity; have incised the drumhead, cut through the posterior fold, divided the tensor-tympani muscle; have removed the whole drumhead and also the ossicula; have even opened the mastoid antrum; have used many local applications to the mastoid, and given all kinds of medicines. Some years ago Prof. Lucar, of Berlin, recommended alternate compressing and rarefying the air in the external ear, but gave the method up, saying it gave rise to inflammation. Prof. Delstanche, of Brussels, recommends this procedure in cases of sclerosis or dry catarrh, and has an instrument devised which he attaches to a Siegle's pneumatic speculum so as to watch and regulate the degree of action. The apparatus is powerful enough to break up some adhesions of the drumhead. Hommel recommends pressing the tragus into the external meatus with the finger 120 times a minute, five or six times a day for one or two minutes. Several authors have tried this without any good results, Rohrer indeed says it decreases the hearing in some cases decidedly. Prof. Lucar now proposes a "pressure probe" for some cases of chronic middle-ear catarrh. The end of this, covered with cotton or gum, is pressed on the short process of the malleus and moved up and down from two to ten times; in this manner seeking to break up any slight adhesions and loosen the joints of the ossicula. In some cases this is not painful, but in others it is very much so, nor does cocaine help it any. Lucar only uses it where Rinne's test has proved negative, and speech is imperfectly heard, and where the Politzer's and Eustachian catheter were also useless. Of forty-four cases he failed to improve seven, gained slight improvement in fourteen, much improvement in ten, and in thirteen improvement was very marked. Eitelberg used this method in thirty promiscuous cases, and in only a few gained improvement, and in none did this improvement prove permanent. I use both Lucar's and Delstanche's methods; at first Delstanche's alone without good results. Lately I uniformly use first the catheter, then Delstanche's, and afterwards Politzer's; and

with this sequence have gained some very good results. It is only when these previous efforts are useless, and in cases selected in the same way as Lucar, that I use his "concave pressure probe." Out of sixty-four such cases it has given good results in twenty, five of these being permanent and eight not heard from on its lasting quality; one case became decidedly worse.—*Brit. Med. Jour.*, May 24, 1890.

REPORT ON THE SURGERY OF THE BLADDER AND URETHRA.

BY CHARLES A. POWERS, M.D.

Of recent contributions to the surgery of the bladder and urethra, those on *supra-pubic cystotomy* are numerous and of very great value and importance. While no new details in technique have been put forth, the recorded cases show that it is rapidly gaining in favor as an easy, feasible, and intelligible route to the bladder, and that the restrictions which have been put upon its use are daily lessening. For the extraction of stones of greater or of lesser size it is coming more and more into use, while as a means of access to tumors it has now no competitor.

Electrolysis in strictures of the urethra finds now and then an advocate, but the better class of surgeons are inclined, we think, to look upon it with a lack of confidence.

The teachings of *Otis*, both as to the relationship between the circumference of the penis and the normal calibre of the urethra, and his views on the dependence of deep spasmodic strictures on anterior narrowings of large calibre, are receiving a constantly widening recognition both at home and abroad.

Exchanges bring to us the usual number of articles on gonorrhœa, yet we find in them nothing worthy of special note. A given man treats a case or two by a special method, and under his guidance, symptoms rapidly subside. He heralds forth a new and uniformly quick form of cure, but it does not stand the test of time. In this connection, it seems to the editor that a remark made by one of the physicians at the late meeting of the Association of Genito-Urinary Surgeons is particularly worthy of impress upon the general practitioner to whose notice these lines may come. This was a man of very wide experience who said that "in his opinion a case of clap which recovered in six weeks was doing very well."

Harrison (Reginald) on the "Whip" Bougie.—This distinguished urethral surgeon says:

"I believe these are by far the best and safest bougies we can employ in most cases of tight stricture. They are made in different sizes, in lengths of about twenty inches, commencing by a filiform point, and gradually increasing towards the other extremity. In speaking of the value of these instruments, in the treatment of tight strictures especially, I am sure that a trial by those unacquainted with them will ensure their adoption in that class of strictures where the difficulties of instrumentation are the greatest. In my own hands they have had an extended trial, and when I have demonstrated their employment to others, their adoption has generally followed. It is no small recommendation to say of an instrument of this kind, that it rarely fails to pass a stricture, so long as it is structurally pervious, however fine the passage may be; that dilatation necessarily follows upon this without risking the re-introduction of a bougie on a larger scale; and that these advantages can be secured without the liability to laceration and hemorrhage which often accompany the use of other instruments. This is important to remember, as every degree of laceration the urethra receives adds to that kind of tissue of which an organic tissue consists. Further, by reason of the tapering form of this bougie, every introduction of it not only stretches the stricture, and increases its calibre by several sizes of the French gauge, but it tends to make the entrance to the stricture from the front funnel-shaped, and thus adds to the ease with which subsequent introductions are effected, either by the patient or the practitioner."—*Provincial Med. Jour.*, Feb. 1, 1890.

Taylor (R. W.) on Unusual Modes of Infection with Syphilis.—Dr. Taylor reviewed the generally recognized modes, both direct and mediate, of origin of acquired syphilitic infection. He then reported cases in which the evidence was very conclusive that the syphilitic infection originated in the following ways: (1) By means of chewing-gum; (2) by one man to

another, by means of an unnatural practice; (3) probably from a cadaver; (4) by means of a caustic-holder; (5) by means of a handkerchief; (6) probably from a bathing-suit; (7) probably from a syringe; (8) probably by means of a pair of drawers; (9) by means of adhesive plaster, or through dressing of a wound; (10) probably contracted in a water-closet; (11) probably from a conductor's whistle; (12) probably from a tongue scraper; (13) probably from a towel; (14) probably by means of a pillow; (15) probably from a razor; (16) by means of the fingers. All the foregoing cases carried with them important lessons, and many of them should teach physicians that, besides treating their syphilitic patients, they should explain to them how they might become foci of infection, and make clear to them the means of preventing that great disaster to others.—*Boston Med. and Surg. Jour.*, June 26, 1890.

Taylor (R. W.) on Chancroidal Phymosis.—The author commends lateral incisions in bad cases; cutting back, with scissors, on either side until he struck the fossa at the base of the glans. Having made these cuts, he soaked the part well in warm water, got off all the *débris*, did not cauterize, washed with five per cent. carbolic acid, dried as well as possible, dusted in iodoform and tucked all around the glans thin layers of absorbent cotton, then brought the parts together with a bandage so as to exert pressure. The little flap which corresponded to the upper half of the prepuce on top withered up into a little three-cornered-shaped flap. One had very soon a *point d'appui* upon each side in the shape of cicatrices. This little flap may be cut off after healing has well advanced, and a few stitches put in. The results were good. This was dividing the operation into two steps; but it immediately made one master of the situation, and the subsequent operation could be done at any time. By this procedure he had saved the integrity of many organs where the ordinary circumcision would have produced greater or less destruction.—*Bost. Med. and Surg. Jour.*, June 26, 1890.

Battle (W. H.) on Tubercular Ulceration of the Bladder.—The patient was a single girl aged twenty. There was a maternal history of phthisis, and for ten months she had had some increased frequency of micturition, with some pain before the act. The urine had been thick, and at times had contained blood. On admission, she was obliged to pass urine every hour and a half, and there was a feeling of fulness and an aching pain, which were relieved by the emptying of the bladder. The urine was slightly alkaline, sp. gr. 1015, and contained many pus and some epithelial cells. Twelve days after admission the urethra was dilated, and an ulcerated surface of considerable extent felt at the base of the bladder and posteriorly, while on the right side was a pouch. The surface of the ulcerated area was soft and vascular, and was well defined by a firmer somewhat sinuous margin. It was rubbed with small sponges on forceps, and the bladder afterwards washed out twice a day with boric-acid solution. A few days later the surface was scraped by the finger and by a sharp spoon, but as slight improvement followed, supra-pubic cystotomy was done and the ulcerated area thoroughly erased. The result was good, the patient regaining bladder control very well.—*Lancet*, May 30, 1890.

Keyes (E. L.) on Tuberculosis of the Genito-Urinary Tract.—Keyes believes tuberculosis to be a general malady with local expressions. He thinks that the infection takes place through the blood-vessels, that some cases may be cured by extirpation of the affected part or by scraping, while others will refuse to yield to such measures.—*Bost. Med. and Surg. Jour.*, June 26, 1890.

[Improvement in the treatment of this affection would seem to lie in devising means for the *thorough* removal of the affected areas. Unless the excision be radical, recurrence is fairly certain to take place.—C. A. P.]

Deaver (J. B.) on the Use of the Leiter Incandescent-Lamp Urethroscope in the Diagnosis and Treatment of Chronic Urethral Discharges.—The author has found the recumbent position of the patient to be the most satisfactory, on a table or couch of ordinary height, with the knees bent over the edges and slightly separated. The largest tube which the meatus will admit is introduced, and passed gently through the urethra to the bulbo-membranous junction, unless obstruction is met with, when the stylet is withdrawn, the urethroscope adjusted, and the obstructing point examined. Great care is to be exercised in passing the tube, as it may induce bleed-

ing, thus obstructing the field of vision. When dealing with a much inflamed urethra, more or less annoyance will necessarily be caused by a few drops of blood, and when this occurs it can be gently removed by a pledget of cotton carried down the tube by the applicator. In case the pendulous urethra is found normal, the tube may be carried into the membranous urethra by depressing the proximal end, and in this way examination of the deep urethra may be effected.—*Med. News*, June 21, 1890.

Bryson (J. P.) on Tuberculosis Uro-Genitalis.—The opinions expressed by the reader were based upon the clinical records of eighty-four cases coming under his observation. Of these twenty-three were operated upon for the relief or cure of the localized disease. Of these operations seven were upon the testis, fifteen on the prostate and bladder, and one upon the kidney. Dr. Bryson's conclusions were as follows:

(1) That the pathogenic factor reaches the parts involved by way of the hæmatic channels.

(2) That more than one part of the urogenital system is affected very early in the history of the disease, perhaps simultaneously.

(3) That the prostato-vesical and periprostatic regions show by far the greater liability to early involvement.

(4) That all the evidence points to the conclusion that we have to deal, even in its earliest recognizable stages, with a general disease which manifests itself by localizations.

(5) That present experience does not warrant the belief that operations, however extensive, undertaken with the view of excising localized lesions and thereby radically curing the disease, will be successful.

(6) That our chief resource is still in general antitubercular treatment, reserving surgical interference for the palliation and relief of pain, bleeding, and wasting suppuration.—*Bost. Med. and Surg. Jour.*, June 26, 1890.

Burbank (T. S.) on a Case of Profuse Urethral Hemorrhage.—A young man was treating himself for gonorrhœa. Soon after jumping from a carriage one day he felt something trickling down his leg, and on getting home discovered that it was blood which was flowing from the meatus. He himself applied ice to the parts and the hemorrhage ceased, to be followed the next day by a very profuse hemorrhage, when Dr. B. was called. Blood, arterial in character, was found spouting from the meatus with regular pulsations. The loss had been great. There was much vesical tenesmus. The hemorrhage was controlled by a pressure-pad in the perineum, and there was no return for thirty-six hours, at the end of which time another profuse hemorrhage occurred.

The bladder was washed out, and the patient had no marked recurrence, though he passed clotted blood for several days. *N. Car. Med. Jour.*, March, 1890.

Twynam (G.) on Calculus Impacted in Ureter—Removal by Operation.—A child, aged eight, had had pain in the abdomen and hæmaturia at irregular intervals for sixteen months. He had been sounded, but no stone was found. The urine was sometimes clear, sometimes contained a large amount of blood and large mucous casts, but no trace of bilharzia or shreds of tumor. The pain was felt over the pubes and at the tip of the penis after micturition. The temperature varied from 97° to 100°, being subnormal when the blood was present. An exploratory incision in the left linea semilunaris was made, and the left kidney and ureter examined, but no stone was found; a small calculus was detected in the right ureter two inches from the bladder, and when pressed down could be felt by the finger in the rectum. The wound was closed and healed well. The temperature remained normal till the seventeenth day, when it rose to 106°. He had an attack of convulsions three days after the operation, and was unconscious for some days afterwards. Four days afterward an operation was undertaken for removal of the stone through an incision similar to that used for tying the common iliac artery. Some difficulty was found in isolating the ureter, but it was ultimately accomplished, and the stone was extracted with forceps through a linear incision. It weighed 6 gr., and was the size of a No. 2 catheter. The wound in the ureter was stitched with fine silk by means of a fine-eye needle; this was very difficult to accomplish. A drainage-tube was introduced to the bottom of the cavity and the wound was dressed with salicylic wool. Urine, however, soaked freely from the wound for three days, so that the dressings had to be frequently changed. Some suppuration occurred, necessitating the re-

moval of the stitches with which the wound had been closed, and there was some rise in temperature, lasting for a few days. On the fifth day the urine ceased to flow from the wound, which then rapidly healed, and the boy made a perfect recovery.—*Lancet*, Feb. 1, 1890.

Spanton on Hemorrhage into the Bladder; Supra-Pubic Cystotomy; Death.—The patient was a man of forty years, whose urine was being drawn for retention. A No. 8 (English) catheter of silver was used. Shortly afterward the bladder was found distended to the umbilicus. A catheter withdrew only a little blood. Supra-pubic cystotomy revealed a bladder full of blood. This was washed out, and a small, bleeding point seen just at the urethral entrance. The point was touched with perchloride of iron. Death followed in three hours. At the autopsy it was found that the catheter had opened a prostatic abscess and ruptured a small artery. The man was found to have been a "bleeder."—*Lancet*, July 26, 1890.

Davis (J. D. S.) on Epicystic Surgical Fistula for Relief of Vesical Catarrh.—The author recommends direct puncture above the pubes, affirming that he has been able to avoid the pre-vesical peritoneal fold, even when the bladder would hold back two ounces of urine.

He says that, in prostatic hypertrophy, where there is much distention of the bladder, due to retention of urine, and the bladder is prominent above the pubes, a sufficient opening can be made, by a single plunge of a large trocar or knife, for cystoscopic exploration and the formation of the fistula for intra-vesical treatment and drainage. If nothing more than drainage is necessary, the dread and shock of a technical epicystotomy (by a long incision) may be avoided, by giving the patient the benefit of a fistula in the manner suggested. —*Four. Am. Med. Assoc.*, Feb. 8, 1890.

[We think that most surgeons will feel that they afford the peritoneum more safety when they distend rectum and bladder and open in the usual way.—C. A. P.]

Thompson (Henry) on Lithotrity.—At a meeting of the Royal Medical and Chirurgical Society, Sir Henry Thompson communicated a paper in which he analyzed the results of 964 operations for removal of calculi from the bladder, 17 being on children, 14 on women, and the remainder on adult males. With very few exceptions, the calculus removed in each case was exhibited, and full notes had been preserved by the operator respecting all. Sir Henry Thompson sketched the progress of this branch of surgery since he himself first in 1854 performed the operation of lithotrity, the improvements of Clover in 1865 by introduction of the aspirator for *débris*, and Bigelow's great advance in perfecting the proceeding of litholapaxy, being referred to. The great advantages of this last-named improvement were shown in the fact that the mortality in the cases so treated, 325, was hardly more than one half that recorded after crushing at several sittings, the number so treated being 475. Examination of the tables presented showed that children were not more commonly subjects of stone than adults, especially among private patients; that the average age of operation was sixty-two and a half years. Early discovery and removal of the stone were insisted on, both on account of the less risk attending it, and because re-formation might then be better guarded against. Of the 933 adult cases, lithotrity was performed in 800, perineal lithotomy in 115, and supra-pubic lithotomy in 18.

The author commented on the difficulty of deciding generally on the question whether lithotomy or lithotrity was preferable in the case of children. Each case should be decided on its merits. Larger stones could be removed by crushing from old men than from younger ones, because in the former the urethra was much more insensitive, and would tolerate a larger tube. In his own small experience with children, lithotomy was attended with good results.—*Med. Press*, March 19, 1890.

Fenwick (Hurry) on Spontaneous Fracture of Vesical Calculi.—The patient was a man sixty-eight years of age, who had latterly passed quantities of mustard-seed calculi (uric acid). After a course of alkaline waters the calculi grew larger, then broke up and came away in pieces. The apparent value of the treatment was proved, however, to be fallacious. On examination of the fragments it was found that a phosphatic deposit had been formed upon each original stone, and had subsequently split off from it. Each stone was the size and shape of a pea; each consisted of three layers—a thin external shell of urate, a middle, friable, phosphatic zone, and a uric-acid nucleus. These had evidently been manufactured, retained, and

disrupted in a post-prostatic pouch. Three theories had been framed to account for spontaneous fracture of vesical calculi. 1. Rounded stones (pisiform) were split by the swelling of the peri-nuclear zone as a shell by a bursting charge (Ord). 2. Irregular stones, in which the cortex was gradually abraded by urine changes and violence. 3. The inter-penetration of mycelium (Ord). The case recorded went to substantiate the correctness of the first theory.—*Lancet*, April 19, 1890.

Wyman (H. C.) on the Use of Quadrangular Urethral Sounds.—The author claims that the rectangular instrument offers advantages over the old form, and enumerates some of these as follows:

1. They present four points of contact with the stricture, therefore less friction than the round instrument.

2. They are grooved between the angles, and thereby insure the presence of the lubricating medium at the points where it will do most good.

3. They provide a means for applying solvent medicaments to the stricture.

4. They stretch the urethra in its transverse diameter at the point where it is organically diseased or in a state of spasm. —*Am. Lancet*, May, 1890.

[We confess our inability to see, on theoretical grounds, force in the above argument.—C. A. P.]

REPORT ON CUTANEOUS DISEASES.

BY C. W. CUTLER, M.D.

Poncet on Diagnosis of Iodoform Poisoning by the Reaction of the Saliva.—Dr. Poncet, of Lyons, has recommended the following tests in cases of eruptions supposed to be due to iodoform poisoning:

1st. A piece of silver money placed in the mouth is immediately followed by a taste of garlic.

2d. A small amount of calomel mixed with the saliva gives a characteristic canary-yellow color, due to the formation of a mercurous iodide.

This reaction is a very delicate one; a drop of a solution of potassium iodide (1 : 4,000) is sufficient, if placed on calomel, to bring out the yellow color. The patient presented these signs as long as the eruption persisted, and they disappeared progressively during the stage of desquamation. *Med. News*, June 7, 1890.

Eichhoff (P. J.) on Aristol in Skin Affections.—Eichhoff, after using aristol in a large number of skin affections, sums up his conclusions as follows:

1. Aristol is in all cases a harmless drug; it has no poisonous properties, and with its harmlessness has other advantages, *e. g.*, it is odorless.

2. In soft chancres it is superior to iodoform in its healing properties.

3. In cases of psoriasis its action was somewhat slower than that of the best older remedies, chrysarobin and pyrogallic acid, but it has the distinct advantage that it is not toxic, or followed by any unpleasant or deleterious action, and is consequently to be preferred to them.

4. In another group of skin affections, the mycosis, aristol has as good an action as any other drug, its action is in some cases more rapid, and it is certainly less irritant than many other remedies.

5. In ulcus cruris and in tertiary syphilitic ulcerations, a better result is obtained than with any other known drug.

6. In lupus it surpasses all remedies, even the best, both in its harmlessness and the thoroughness and rapidity of its action. —*New England Med. Monthly*, July, 1890.

Ohmann-Dumesnil (A. H.) on the Absorption of Drugs in Ointments.—A number of experiments have been recently conducted with a view to determining which of the ointment bases most readily promote the absorption of active ingredients through animal membranes.

The bases employed were vaseline, lard, and lanolin. The active ingredients were iodide of potassium, carbolic acid, and resorcin. In the case of iodide of potassium, exosmosis commences in one hour when vaseline is used; in nine when lard is employed; and when lanolin is the basis, it is not observed in twenty-four hours. The other substances give similar results. The practical outcome of this is that if the absorption of a drug is desired, vaseline is to be used; but, if non-absorption or superficial action is desired, then lanolin is the proper excipient to employ. The practical bearing of this is important, and it is a very easy matter to remember. Whether the difference in origin of these fats produces this difference in action has not yet been determined.—*St. Louis Clinique*, July, 1890.

Unna on Treatment of Ringworm of the Scalp.—Unna treats all cases of ringworm of the scalp as follows:

All the hair is cut off short from the head. Then a stripe of zinc-glue (zinkleim) is drawn along the line of the hair all around the head. All inside of this boundary line is painted with a 5 to 10 per cent. chrysarobin ointment, or one composed of chrysarobin, 25 grains; salicylic acid, 10 grains; ichthyol, 25 grains; and simple ointment, 1 ounce. An impervious cap of gutta-percha tissue is fitted over the head, so as to come down to the middle of the band of glue, its edge covered in with the zinkleim and a mull bandage. Over all comes a close-fitting flannel cap, which is to be kept in place by bands sewed onto it. The bandage and dressing are to be changed every twenty-four hours. This method of dressing prevents the chrysarobin from getting into the eyes, and absolutely takes away all danger of spreading contagion, so that the child can go to school. After three days the chrysarobin is washed off and a 5 per cent. ichthyol or sulphur ointment substituted for it. At the end of a week the whole head is to be oiled and washed with soap and water. The process is to be repeated every week for three or four weeks.—*Monatshft. f. p. Dermat.*, 1889, ix., 543; *New York Med. Jour.*, June 28, 1890.

Ohmann-Dumesnil (A. H.) on the Treatment of Tylosis.—The callosities should be cut down as much as possible, and frictions with a pumice stone ordered to reduce the callus as much as possible. After this the following application, to be made twice daily:

℞	Acid salicylic . . .	ʒ i.
	Ext. cannabis Indic. . .	℈ i.
	Traumaticin . . .	ʒ j.
M.		

Also absorbent wool under the implicated portions to remove pressure.—*St. Louis Clinique*, July, 1890.

Besnier on Marginate Desquamative—Eczema of the Tongue.—Besnier describes an eczematous disease of the tongue in which it is covered by a whitish coat, marking out the papillæ more prominently than usual. At many places at the edges or upon the upper face of the tongue the papillary plane is broken by rosy-red spaces, at the centre of which some papillæ, from which the white coat has been removed, emerge, and its edge is sharply defined by being somewhat raised and of a more distinct red. The veins on the lower side of the tongue are prominent. Besnier regards the disease as analogous to eczema seborrhoicum of the body, which is often present at the same time upon the scalp or trunk. The part is somewhat painful to the touch. The treatment is by attention to the general condition of the patient, together with very frequently repeated washing out of the mouth with a feebly alkaline water, and the application of a five-per-cent. ointment of boric acid in vaseline.—*Jour. de Méd*, 1889, lx., 602; *N. Y. Med. Jour.*, June 28, 1890.

Dockrell on the Treatment of Ringworm of the Scalp.—Dr. Dockrell, of London, brings forward hydronaphthol as a specific in ringworm, and recommends its use as follows:

Shave the head, and wash it with a 5 per cent. hydronaphthol soap and very hot water; then dry the scalp and apply 10 per cent. hydronaphthol plaster in narrow strips overlapping each other at the edges and going beyond the diseased area. Outside of all he applies a 10 per cent. melted hydronaphthol jelly so as to shut out the oxygen. At the end of four days he removes the plaster and repeats the previous processes, using a 20 per cent. plaster for one week. Then he repeats the processes, and applies a 10 per cent. plaster for ten days, when the disease will be found cured. During the treatment he applies a 5 per cent. hydronaphthol ointment to the unaffected parts.—*Lancet*, 1889, ii., p. 1110; *New York Med. Jour.*, June 28, 1890.

Stourme on Prognosis in Cephalic Chancre.—Dr. Stourme collected more than one hundred cases of chancre on the head, and from a study of these cases came to the following conclusions:

The primary incubation of chancre upon the head is from fifteen to thirty-five days. Its duration presents nothing unusual, lasting on an average forty-nine days. The second period of incubation, instead of being six weeks, as in genital chancre, has been found by the author to be only thirty-eight days. Secondary manifestations are not more severe than those usually seen. Sufficient time has not been given to make observations upon tertiary lesions. Specific treatment has as favorable effect upon the later manifestations as in genital syphilis.—*Lyons Méd.*, June, 1889; *Jour. Cut. and Genito-Urin. Dis.*, Aug., 1889.

Porritt (N.) on Treatment of Pruritus and Irritable Skin.—Dr. Porritt recommends the employment of a cone of cacao butter, impregnated with 2 per cent. of cocaine, in the treatment of pruritus and irritable skin. This is rubbed over the part affected. The warmth of the skin melts off a layer of cacao butter, which forms a soothing emollient shield over the irritable patch. The remedy has been put up in the form of cones, enclosed in boxwood cases with screw tops, something after the manner of menthol cones. In irritable affections of the skin, in cases of insect bite, in pruritus, and various other forms of hyperæsthesia, the remedy is worthy of a trial, and its use has a distinct advantage over the more usual applications. Although containing cocaine, the writer regards the manner in which the cacao butter is spread over the affected part as having a share in the curative process.—*Brit. Med. Jour.*, July 27, 1889; *Jour. Cut. and Genito-Urin. Dis.*, Oct., 1889.

Besnier (E.) on the Treatment of Psoriasis.—Besnier has had great success in the treatment of psoriasis by the use of the following ointment:

℞	Naphthol β	10-0
	Adipis	90.0
M. et ft. ung.		

Apply the ointment with friction every evening to the eruption. On the following morning remove the ointment with warm water and soap, and powder the skin with starch. The treatment may be continued for fifteen days, or until the cure is complete if an amelioration is observed.—*Jour. of Cut. and Genito-Urin. Dis.*, June, 1889.

Piersol (G. A.) on the Development of Pigment within the Epidermis.—After a lengthy consideration of the development of pigment within the epidermis, the author concludes as follows:

1. In the developing epidermis the earliest pigment appears within meso-blastic cells which have entered the epithelium while still uncolored; the pigment is formed within the protoplasm of the cells *in loco*, being neither transported to nor taken up by the cell as preformed granules.

2. Later, after the appearance of pigmented cells within both cutis and epidermis, the pigment cells of the former send processes into the epithelium, and thereby contribute additional pigment to the epidermis; the pigment cells in both localities are in nature identical.

3. There is no conclusive evidence of the origin of pigment within the epithelial cells of the epidermis.—*University Med. Mag.*, Aug., 1890.

Noyes (A. W. F.) on the Lichen Group.—The term lichen was formerly applied to any papular disease of the skin, but is now restricted to such diseases as remain papular throughout their course, never undergoing any further development. With this understanding as to the meaning of the term lichen, but four diseases compose the lichen group, viz.: lichen rubra acuminatus, lichen planus, pityriasis rubra pilaris, and lichen scrofulosorum.—*The Australian Med. Jour.*, June 15, 1890.

THERAPEUTICS.

Pneumonia and Bloodletting.—M. Crocq, who has frequently written and spoken in favor of the revival of venesection, made a powerful speech dealing with this subject at a recent meeting of the Belgian Académie de Médecine. Speaking of pneumonia, he declared his disbelief in the cause of the disease being either Friedländer's bacillus or the diplococcus of Fraenkel and Weichselbaum. Inoculation of this latter microbe, he remarked, is said to procure immunity from subsequent inoculations, which is exactly contrary to the effect of an attack of pneumonia, for it rather predisposes the subject to subsequent attacks. Again, M. Crocq injected sputum from pneumonic patients, in which the diplococcus had been found, into the lungs of four rabbits, but none of them contracted pneumonia. Lastly, in a doubtful hospital case the sputum was examined and found to contain the diplococcus, but at the post-mortem examination no pneumonia was discovered. M. Crocq has never met with any cases of contagion in pneumonia, and Finckler's cases he considers were not pneumonia at all. Moreover, Fraenkel's microbe is found in affections which are neither pneumonia nor contagious. The mortality usually reported by other observers in pneumonia varies greatly—that is to say, from 5 to 35 per cent. M. Crocq has no mortality at all. He arrests all his pneumonia cases by bleeding. Rheumatic fever, and even puerperal metro-peritonitis,

he treats in the same way. The latter, he declared—amidst tokens of dissent—can be thus cured in the great majority of cases. "Never," he went on, "have I regretted having bled a patient, though I have often been sorry that I have abstained from doing so. . . . If I were to be forbidden to bleed, I would give up the practice of medicine." He was of course careful to explain that bloodletting, to be of any service, must be practised intelligently and not abused, as he fears it may again come to be after the wave of reaction has once more made it popular.—*Lancet*, Aug. 9, 1890.

Rothziegel (A.) on Strophanthin.—The single dose was from $\frac{1}{300}$ to $\frac{1}{100}$ gr., and the daily dose from $\frac{1}{10}$ to $\frac{1}{12}$ gr. The drug was given either in solution or in the form of capsules of $\frac{1}{100}$ gr., or in hypodermic injections. The results were as follows: 1. The circulatory system was very favorably influenced, the effect chiefly consisting in strengthening and regulating the pulse. The pulse became stronger even after small doses, and in a very short time (from five to ten minutes). The arhythmia of the pulse was influenced later, in most cases on the second or third day after the administration of the drug. The effect, in general, occurred later than after the use of digitalis, but when the drug was further continued, its effect lasted for a considerably longer time, and also persisted for a certain time after its discontinuance. 2. It was particularly the disturbances of the heart's action which occurred in various organic diseases of that organ, and especially dyspnœa and palpitations, which were favorably influenced by strophanthin. 3. The urinary secretion was considerably increased after the adminstration of strophanthin but not so much as by digitalis or tincture of strophanthus. The increase also persisted for several days after the discontinuance of the drug, and seemed to be due to increase of the blood pressure, rather than to a direct effect on the kidneys. 4. Gastric disturbances were exceedingly rare, and, when these occurred, strophanthin was administered in capsules, and was well borne. Increase of appetite was frequent. The action of the bowels and perspiration were not influenced by strophanthin. 5. The nervous system was influenced indirectly by the regulation and strengthening of the cardiac activity. 6. A cumulative effect was not observed after the use of strophanthin. 7. Subcutaneous injections of aqueous solutions produced rapid and permanent strengthening of the pulse, and when carried out under strict antiseptic precautions no local or general irritative symptoms were observed. 8. The tincture of strophanthus was on the whole preferable to strophanthin; it was more certain, rapid, and energetic in its effect, especially as regards the urine. Where, however, neither the tincture nor digitalis was well borne, strophanthin was often a useful substitute. 9. The indication for strophanthin in valvular affections, with and without affections of the myocardium, as well as in organic affections of the cardiac muscle alone, was insufficiency of the heart's action with the symptoms resulting therefrom. In acute and chronic Bright's disease, as well as in pleurisy, strophanthin was a diuretic only when the scantiness of the urinary secretion was due to cardiac insufficiency. In tubercular pleurisy it had no effect.—*Br. Med. Jour.*, June 7, 1890.

Stockman (R.) on the Excretions of Balsams in the Urine.—As a result of these observations, it seems to be proved that balsam of Peru, storax, benzoin, and the balsam of Tolu can be given in as large a dose as is ever desired in practice, without any risk of producing albuminuria, or nephritis. The amount of irritation which they cause is never sufficient to injure the healthy kidney, although it may irritate seriously one which is already diseased. In some (at least) of the recorded cases of albuminuria, after the adminstration of balsams, a resinous body in the urine has been mistaken for albumen.—*Brit. Med. Jour.*, June 14, 1890.

The Effects of Diuretics.—Several St. Petersburg degree theses this year deal with the subject of diuretics and their effects. Dr. Alexêeff finds that digitalis increases the excretion of water by the kidneys, but lessens that by the skin, the ratio of the total quantity excreted to that absorbed not being increased, and the effect of nitrate of potash being much the same. Both these substances, too, raise the blood pressure. Dr. Atlasoff, who has examined the effects of diuretics on the metamorphosis of potash, soda, lime, and magnesia finds that both digitalis and nitrate of potash increase the metamorphosis of soda in the body and its excretion by the kidneys, its absorption being promoted by digitalis and sometimes by nitrate of potash. Digitalis increases both the absorption and metamorphosis of

potash, but nitrate of potash, though it slightly increases the absorption, diminishes the metamorphosis. Digitalis and nitrate of potash somewhat diminish the absorption of lime, the former increasing and the latter decreasing the metamorphosis. The excretion of magnesia by the kidneys and its metamorphosis are somewhat lessened by digitalis, but are generally increased by nitrate of potash, its absorption being promoted by nitrate of potash and usually retarded by digitalis. Dr Bêlkoff finds that the metamorphosis of chlorides, phosphates, and sulphates is promoted both by digitalis and by nitrate of potash, the former drug exerting its effects for some time after the day of its administration, but the latter having a more transient influence. Dr. Serezhnikoff finds that digitalis, when it has any effect on the nitrogenous metamorphosis, tends to increase it. It always, however, improves it qualitatively—*i.e.*, increases the metabolism.—*Lancet*, June 14, 1890.

Wood (H. C.) on Anæsthesia.—According to the author, the rules for the proper treatment of accidents during anæsthesia can be summed up in a very few words:

Avoid the use of all drugs, except strychnine, digitalis, and ammonia.

Give the tincture of digitalis hypodermically.

Draw out the tongue, and raise up the angle of the jaw, and see that the respiration is not mechanically impeded.

Invert the patient briefly and temporarily.

Use forced artificial respiration promptly, and in protracted cases employ external warmth and stimulation of the surface by the dry electric brush, etc., and above all, remember that some at least, and probably many, of the deaths which have been set down as due to chloroform and ether have been produced by the alcohol which has been given for the relief of the patient.—*Jour. Am. Med. Assn.*, Sept. 13, 1890.

McWilliam on the Action of Chloroform and Ether.—In these experiments, made on cats, the animal was first of all anæsthetized, and then a certain definite amount of air was passed over a drop or two of chloroform contained in a bottle, and pumped into the trachea. Three or four per cent. of chloroform vapor was thus used, and the degree of anæsthesia attained was tested by the conjunctival reflex. In the case of the heart in chloroform inhalation, it was found that there was a tendency to dilatation of all the chambers, which was not seen when ether was the anæsthetic agent made use of. Among the animals experimented upon death frequently occurred from the inability of the heart to carry on the circulation, although the respiration continued for a considerable time. In such cases the heart might still move a little, but its action as a pump had ceased. The fall of blood-pressure when chloroform was administered was protective, if taken in quickly; but in some cases the heart became rapidly affected and the animal died. In reply to a question by Dr. Drysdale, the author said that as far as it was possible to draw conclusions from experiments on the lower animals, ether seemed to be a much safer anæsthetic than chloroform. There was also a curious after-depression in the case of chloroform not met with when ether was used. The measurement of the dilatation of the heart was made by its action on a level resting on it when the chest was laid open.—*Med. Record*, Sept. 6, 1890.

Local Anæsthesia.—Dr. A. Dobisch of Zwittau has used, for the purpose of producing local anæsthesia, a spray, with Dr. Richardson's ether spray apparatus, compose of ten parts of chloroform, fifteen parts of sulphuric ether, and one part of menthol. After one minute's application of this spray complete anæsthesia of the skin and neighboring tissues was obtained, which lasted for from two to six minutes, and sufficed for the performance of such minor operations as opening abscesses of the cervical glands, incising a deeply seated whitlow, and the excision of an epithelioma of the nose. In all the cases in which he employed the spray above-mentioned the wounds healed quite satisfactorily.—*Lancet*, June 14, 1890.

Jennings (O.) on Cure of the Opium Habit after Twenty Years' Addiction.—The gentleman in question was a member of the medical profession, and had repeatedly failed in his attempts at self-cure at the critical moment. The suppression of the drug had been effected in three weeks, and ten days had elapsed since the last dose was taken. The patient stated that he was still suffering from prostration, and from intermittent pain, but he felt none of the horrible craving for opium that compelled to the use of that stimulant.

The treatment was that always adopted by Dr. Jennings, the chief remedies employed being heart tonics and trinitrine in the form of the compound tabloids, galvanization of the brain, hot water and hot air baths had also been used, together with other occasional prescriptions.—*Lancet*, June 14, 1890.

Treatment of a "Cold" by Pilocarpine.—On the evening of the 23d ultimo, being troubled with a severe "cold," nasal catarrh, coryza, and a slight attack of bronchitis, and having tried all the usual remedies, I went to bed at 11.20 P.M., and took six tabloids of muriate of pilocarpine, twentieth of a grain each, and also twenty-five minims of tincture of opium. In five minutes' time my pulse increased to 94, and my temperature to 102°. Salivation commenced, followed by profuse perspiration, progressing from head and chest downwards, also a marked rigor. In ten minutes my pulse was 120, and temperature 103.4°, the perspiration increasing. In fifteen minutes my pulse fell to 80, and temperature to 99.8°, afterwards falling to 98°. I tested the saliva and sweat, and found urea in both. The perspiration lasted an hour and a half, and was accompanied by painful strangury. I slept afterwards for six hours, and rose and enjoyed my cold bath as usual in the morning, and every symptom of the cold had vanished.—Anonymous correspondent, *Lancet*, Jan. 4, 1890.

Blackman (J. G.) on Pilocarpine in Dryness of the Tongue.—Extreme dryness of the tongue is, under any circumstances, a very distressing symptom, and one which does not readily yield to treatment whilst the concomitant cause remains in operation. The sucking of ice or sipping of bland fluids gives but temporary and inadequate relief, and the same may be said of glycerine employed as a paint. In this condition I have successfully used pilocarpine, gr. $\frac{1}{30}$ or gr. $\frac{1}{10}$, in the form of a gelatine lamel allowed to dissolve on the tongue previously moistened with a sip of water. I find this small dose quickly establishes a moderate flow of saliva which persists for at least twenty-four hours, and is unaccompanied by excessive perspiration. The altered state of the mouth is often described by the patient as being delightful. I send this not with the hope that others may share the satisfaction I have experienced, if they have not already done so, in this use of pilocarpine. It is scarcely necessary to add that we must exercise due caution in the use of so potent a remedy.—*Brit. Med. Jour.*, June 14, 1890.

Pilocarpine and Chloral in Tetanus.—A case of tetanus, in which a cure was effected, is reported from the St. André Hospital, Bordeaux. Chloral was administered for the tetanic contractions. Subcutaneous injections of pilocarpine and constant steam baths were employed to eliminate the toxic ptomaines.—*Brit. Med. Jour.*, April 19, 1890.

Eagleton (S. P.) on the Action upon the Circulation of Alcohol when Continuously Injected.—A comparison of the results of my experiments with those obtained in the experiments of others, and with our clinical knowledge of the action of alcohol, would seem to insure their accuracy. In conclusion I have found:

First.—Dilute alcohol in small doses, frequently repeated, increases cardiac force and arterial pressure. Large doses at first increase, then decrease, arterial pressure, followed by a partial rise to normal, and finally a progressive fall of pressure until death: at the same time the frequency of the heart's beat is at first decreased, though there is sometimes a primary increase; it then partially returns to normal, and is subsequently again decreased.

Second.—Strong alcohol in small doses generally increases both pulse rate and cardiac force.

Third.—Toxic doses decrease at once the rate and force of the cardiac beat, and diminish greatly arterial pressure.

Fourth.—These different phenomena are due to a direct action of the alcohol upon the heart.

Fifth.—The results obtained by different experimenters vary chiefly because of the difference in the strength of the alcohol used, the manner of administering the drug, and in the kind of animals used.

Sixth.—The clinical belief that small doses of alcohol increase the force of the circulation by directly acting upon the heart is sustained.

Seventh.—Alcohol in small doses is a cardiac stimulant; in large doses, a cardiac depressant.

Eighth.—The depressing action of the drug upon the circulation is an important factor in acute alcoholic poisoning.—*University Med. Mag.*, Sept., 1890.

Bacelli on the Intra-Venous Injection of Quinine.—In pernicious malarial fevers, gastric and subcutaneous resorption are much interfered with. Accordingly quinine was injected directly into the veins. A prompt effect was seen. But as much as fifteen grains of the hydrochlorate of quinine were administered in this way before decided amelioration occurred. No unpleasant consequences were observed to follow this procedure. The formula employed by Dr. Bacelli was as follows :

Quin. hydrochloric.....	1.0	gramme.
Sod. chlorid.....	0.075	"
Aq. destillat.....	10.0	grammes.

He directs that the fluid is to be filtered, warmed, and injected into a vein of the forearm, under strict antiseptic precautions.

The success of this method of treatment is said to depend in large measure upon the time of injection. If the injection be given before the febrile attack has already begun, even fifteen grains will not suppress the paroxysm. So, too, when practised during the acme of the seizure defervescence is not hastened. The most suitable time is the period of natural subsidence of the febrile movement. Given at that time, the next anticipated attack is either entirely suppressed or considerably reduced in intensity.

In subcontinuous fever injections practised during defervescence are particularly efficacious.

But in spite of the good results thus obtained Dr. Bacelli is not an advocate of the indiscriminate application of the intravenous method. For, says he, in ordinary malaria thirty grains of quinine, given by the mouth or injected subcutaneously, usually fulfil every indication. It is only when quinine is found inert if administered this way, and more particularly in the pernicious forms of fever, that he strongly urges the intravenous injection of the drug.—Editorial, *Med. Record*, Aug. 30, 1890.

Barker (L. F.) and Wright (A. H.) on a Case of Tetanus of the Uterus, Treated by Antipyrin.—I. A., aged twenty-two, primipara ; has always been well, with the exception of leucorrhœal discharges, which have been present for the last two years. Habits have been sedentary. Pelvic outlet slightly narrowed. Pregnancy normal. There was prolongation of first stage of labor owing to rapidity of os extern. cervicis and premature rupture of the membranes. Three 15-grain doses of chloral hydrate were given to assist in relaxation of the os, but twenty-four hours elapsed before the completion of the first stage. The head descended rapidly until the middle of the vaginal canal was reached, when progress became slow. At the end of forty hours the head was well down on the perineum, but as the latter remained very rigid, and the vaginal outlet much contracted, the pains became ineffectual. Up to this time the general condition of the patient had been satisfactory, but symptoms of exhaustion now began to appear. The pains became shorter and more frequent. The pulse rose to 100 and over, and patient complained of nausea and thirst. Before very long it became impossible to make out distinct intervals between the pains, and on examination the uterus was found retracted, and in a state of *tonic* contraction. Dr. A. H. Wright ordered 15-grain doses of antipyrin every fifteen minutes for three doses. Before the second dose had been given, patient felt easier, and the tonic internal contractions could again be made out. After the 45 grains had been taken the pains were about three minutes apart, and the tetanic contractions had disappeared. The head, however, being very large in proportion to the outlet, and no advance being made, chloroform was given, and the house surgeon, Dr. L. F. Barker, applied the forceps and delivered the head by gradual traction. The uterus did not contract down well, and some blood was lost. Ergot was administered in one-drachm doses, and the uterus watched closely for three quarters of an hour, when it contracted well. The results obtained from the administration of antipyrin in this case would justify its use early in uterine tetanus, before the muscle fibres and nerve centres are exhausted by prolonged tonic contractions. It would seem probable that the drug acts directly on the nerve cells in the parturient centre in the lumbar cord, lessening their irritability.—*Canadian Practitioner*, Aug. 19, 1890.

Tellurate of Potassium in the Night-Sweats of Phthisis.—Tellurium has been known for some time to have a poisonous effect on dogs, producing vomiting and stupor, and tainting the breath for a considerable time with a

garlic-like smell, and quite recently Dr. E. Neusser, of Vienna, has made trial of it in the form of tellurate of potassium as a remedy for phthisis, thinking it probable that such a substance might exert a bactericidal effect. He gave it in about fifty cases, and found that in by far the larger number one third of a grain daily in the form of a pill was sufficient to arrest the night-sweats, or at least to moderate them very perceptibly. In a few instances it was necessary to double this dose, and this was usually sufficient to bring about the desired result. No toxic symptoms were produced unless at least a grain was given daily for some considerable time, and then indigestion was set up. Of course the garlic-like smell which the breath always acquired was not very desirable, but it was not generally perceived by the patients themselves. Dr. Neusser thinks these preliminary trials afford sufficient ground for further observations on the action of this drug.—*Lancet*, Aug. 16, 1890.

Camphor a Solvent of Iodoform.—The addition of camphor to ether or alcohol increases the quantity of iodoform it is capable of dissolving. Olive oil saturated with camphor dissolves six per cent. of iodoform.—*Med. Press*, Aug. 20, 1890.

Relief by Compressing the Neck in Tabes Dorsalis.—M. Mossé, of Montpellier, reported the case of an ataxic arrived at the cachectic period of the disease, in whom compression of the neck brought great relief to many of the most distressing symptoms, such as the gastric crisis, the sensation of cervical and thoracic constriction, etc., the duration of the relief varying from time to time, but always capable of being renewed by this simple means. He suggests, as to the precise way in which the procedure acts so beneficially, that it may be analogous to the similar relief afforded by the compression of special zones in hysteria, or the painful points in certain forms of neuralgia. As to the nerves, by way of which the relief is conveyed, the pneumogastric would appear to be the most likely; but in consequence of the complex anatomical condition of the region of the neck, it is not easy to say which of the nerve trunks here situated determines the desired inhibitory action. Therefore, without prejudice to the physiological mechanism concerned, M. Mossé would restrict himself to recording the fact that lateral pressure of the cervical region finds an undoubted result in modifying the distressing symptoms above-named.—*Lancet*, Aug. 30, 1890.

Edwards (L. B.) on Salines in Peritonitis and Typho-Malarial Fever.—There had been hesitation and fear in regard to using the suggestion from lack of accuracy in differentiating typhoid and typho-malarial affections. He was confident that if this treatment was adopted a decided inroad would be made in the direction of shortening the duration of typho-malarial fever. This idea was sustained by eminent authorities. He did not positively advocate this plan, but suggested it. Whereas a doctor would do well ordinarily to bring a case of typho-malarial fever to a close in fifteen or twenty days, he had completed two cases in about eight days with the use of salines and such antipyretics as acetanilide, antipyrine, and quinine. Fluid diet was as essential as medicines. In using the antipyretics he had guarded them with heart tonics, preferably strophanthus. —*N. Y. Med. Jour.*, July 19, 1890.

Lactic Acid in the Treatment of Diarrhœa.—In small doses (one to two fluiddrachms), lactic acid is a valuable aid to digestion and, in view of its anti-putrefactive powers, it is of service in the treatment of various forms of diarrhœa. When given in small doses its effects are confined to the stomach, but in larger doses (over two drachms) it appears in the urine and fæces; hence, when desired, its topical effect on the large intestines can be obtained. A very good formula is to present it in the shape of a lemonade containing about one part of the acid in a hundred with syrup and water. Dr. Hayem claims to have derived great benefit from it in the treatment of *cholera nostras* as well as in the diarrhœa due to tuberculous lesions of the intestines and other varieties of gastro-intestinal irritation.—*Med. Press*, Aug. 13, 1890.

The Influence of Drugs on Absorption.—The importance of a knowledge of the process of absorption taking place in the intestine cannot be over-rated, and consequently any addition to our information on this subject is to be welcomed. The absorption of drugs by the intestine has been very little investigated, and it is on this point that Leubuscher, of Jena, has made some experiments. The process of absorption must no longer be considered a purely physical one, but a function of

living cells, so that any causes which may injuriously affect the life of these cells will also interfere with proper absorption. The cells may be altered by influences acting directly on themselves, or through the blood current, or through means of the nervous system. With regard to direct injury of the cells, Leubuscher experimented by isolating a small coil of intestine in a living animal by means of light ligatures, and then injecting a strong solution of a mineral acid, washing this out with water and introducing a known quantity of grape sugar in solution. Compared with a normal intestine, the quantity of grape sugar absorbed was considerably lessened. In other experiments, the artery supplying the coil was tied, or the vein leaving it, producing in the one instance anæmia and in the other congestion; in both cases, but more especially in the latter, absorption was greatly interfered with. Investigations as regards the third division—namely, the effect on the nervous system—could not be fully carried out. The action of various drugs was then tried. Grape sugar and a solution of iodine in iodide of potassium were used as tests of the power of absorption, and the following drugs were selected: Quinine, opium, alcohol, glycerine; also weak solutions of common salt and Carlsbad waters. Coils of intestine were exposed and isolated in two animals. In one the grape-sugar or iodine solution alone was injected, and in the other the same mixed with the drug to be tested. The results were afterwards corroborated in animals in whom an artificial intestinal fistula had been secured. Quinine, opium, and morphia, even in weak solutions, interfered greatly with absorption. Morphia acted in the same manner when it was introduced into the system by means of hypodermic injections. Alcohol in weak solutions (5 to 2 per cent.) increased absorption, but in larger quantities hindered the process. Glycerine produced no decided effect, weak solutions of common salt increased, and Carlsbad water had no effect on absorption. A few experiments were also tried by estimating the quantity of iodide of potassium passed within a certain time in the urine of patients after a dose of this drug had been administered by the mouth, the iodide being dissolved either in water, alcohol, glycerine, Carlsbad water, or milk. With alcoholic solutions the quantity was increased as compared with the watery solutions; with glycerine, this was the same as with water; Carlsbad water also increased it, but milk lessened the quantity. —*Lancet*, Aug. 16, 1890.

The Relative Germicidal Powers of Disinfectants.—According to some researches carried out by a Berlin bacteriologist, even corrosive sublimate is not the powerful and absolute germicide that it is supposed to be, and his observations bearing thereon are interesting, because only the possession of undoubted antiseptic properties can be held to justify the use of such a dangerously poisonous agent. He found, for instance, that the vitality of anthrax-spores under certain circumstances was not destroyed even after twenty minutes' immersion in a one-per-thousand solution of the salt, and animals inoculated therewith died of splenic fever. The inefficiency of solutions of carbolic acid has long been proclaimed, and in the course of his researches this observer found that after thirty-eight days' immersion in a seven-per-cent. solution of the acid, anthrax spores were still capable of growth and of infecting animals. With respect to boiling water, one minute's immersion was totally inadequate to prevent further development, and two minutes did not preclude the cultivation of the spores in agar. It was only after five minutes' boiling that their career appeared to be cut short. It is a curious point that in the case of boiling water the spores would grow after they had proved harmless to animals, whereas with sublimate the opposite occurred. The loss of power to develop, therefore, does not involve the inability to infect animals, and the latter test has, therefore, been made the criterion of perfect disinfection. Passing over the details, he found that chlorine was by far the most reliable disinfectant and germicide, a watery solution containing a two-per-cent. of the gas, destroying in fifteen seconds the infectiveness and power of growth of the bacilli. To cleanse the hands he recommends a paste consisting of a hundred parts of "chloride of lime" with forty-five of water, to be smeared on as with an ointment, the hands to be then rinsed in a two-per-cent solution of hydrochloric acid. The great objection to conclusions based on the foregoing observations is that the experiments bore on only one variety of micro-organism, and we have no sort of assurance that the bacilli with which we have more commonly

to deal are correspondingly amenable to the various germicidal agents.—*Med. Press*, Aug. 20, 1890.

Death from an Overdose of Paraldehyde.—The deceased, aged twenty, was admitted suffering from typhoid fever, and but slight hopes were entertained of her recovery. As she was suffering from violent delirium and sleeplessness, a hypnotic was prescribed, and the temporary nurse was instructed, both verbally and in writing, how to administer the medicine. The patient getting worse, the nurse overlooked the directions she had received, and, instead of giving one teaspoonful, unfortunately administered the entire contents of the bottle, viz., from six to seven teaspoonfuls. In about five minutes the patient fell into an unconscious state, and, despite medical assistance, remained in that state for four hours, when she died. The quantity of paraldehyde that was administered is not mentioned, but it may be supposed the deceased girl took from six to seven drachms. The resident medical officer of the workhouse, in giving evidence at the inquest, is reported to have said that weakness of the heart's action was accelerated by the overdose. This appears strange, as it is usually believed that paraldehyde, instead of weakening the heart, like chloral, strengthens it, and diminishes its frequency. It is for this reason that it is especially valuable in the insomnia of cardiac affections. The coroner's jury returned a verdict that death resulted from failure of the heart's action, accelerated by an overdose of medicine administered while in a weak condition from fever.—*Lancet*, Aug. 23, 1890.

Sée (G.) on the Treatment of Dyspepsia by Cannabis Indica.—At the Académie de Médecine the author read a paper on the "Treatment of Dyspepsia and Certain Other Gastric Affections by Cannabis Indica." He said that the drug should be employed in the extract at the dose of one third of a grain three times a day. It acts by suppressing the painful sensations experienced after the ingestion of food, and excites the appetite. However, when an excess of hydrochloric acid is present in the stomach, large doses of bicarbonate of soda should be given at the end of the digestion in the stomach—that is to say, four hours after food had been taken. The Indian hemp had no effect on atony or dilatation of the stomach, but it acts favorably on spasm and vomiting of a nervo-motor origin. In the case of pyrosis the effects of the drug were very pronounced. In conclusion, M. Sée said that cannabis indica was an *effectual sedative* of the stomach.—*Brit. Med. Jour.*, Aug. 6, 1890.

The Degeneration Caused by Phosphorus Poisoning.—Dr. Nathanson, in a Berlin graduation thesis, discusses the effect of phosphorus poisoning on the liver. He follows Virchow in drawing a sharp distinction between the infiltration of the liver cells by fat globules and their metamorphosis into fat. He treated hardened sections with ether and found that when these were from a healthy subject no change was produced thereby; when they were from a liver affected with fatty infiltration, the fat globules were dissolved, the remaining cell structure remaining pretty much as it had been before. When, however, the sections were taken from bodies which had died of phosphorus poisoning, the structure was entirely obliterated by the ether, and the same occurred in the case of sections of the kidneys from the same subjects. The inference is that poisoning by phosphorus produces a true fatty metamorphosis of the tissues of the liver and kidney.—*Lancet*, June 28, 1890.

Jones (C. H.) on the Toxic Effects of Castor Oil.—A vigorous youth of twenty-three, muscular and active, but with some neurotic tendencies, was seen on October 17th, when he had been ailing three or four days. Early symptoms were pain in left side of chest, indigestion, headache, rather dull than acute, intolerance of light and noise. Temperature 101.8°. Pulse 117, soft. Bowels not open. Spleen a little enlarged. No tenderness in abdomen. No typhoid spots. Temperature rose to 103.8° about 7 P. M. Hydr. creta, gr. 2; extr. rhei, gr. 2, in pill, was given at 1 P. M., but as it did not act ℥ ss of ol. ricini was sent on the same errand at 10 or 11 P. M. About midnight oil acted copiously; while at the w. c. he fainted, was pulseless when aid came, but was rallied by whiskey, and slept well after.

18th.—This morning: Pulse 88, soft; temperature 99.8°. Head cooler, less headache, no diarrhœa. Temperature at 11 P. M. 99°; pulse 84. Feels much better. Soon got well.

A vigorous man, of middle age, a good mountaineer, but with gouty tendencies,

was attacked, while out for his holiday at a well-known Swiss climbing centre, with pain in left lower chest, which persisted when I visited him about two days later. I found his pulse exceedingly irregular, the beats varying much in size and force. His case appeared to me one of gouty pleurodynia, or dry pleurisy, there being no unequivocal physical signs of effusion. A Swiss practitioner regarded the pain as the result of fæcal accumulation at the junction of the transverse and descending colon and prescribed castor oil. Soon after the second dose he got out of bed and fainted away but was soon rallied by stimulants, and in a week was able to resume climbing. —*Med. Press*, July 9, 1890.

Idiosyncrasy Regarding Tannin.—Dr. Lange, of Copenhagen, mentions a case in which a patient presented a rare idiosyncrasy regarding tannin locally applied. He was a gentleman about thirty years of age, who was suffering from catarrh of the nose and pharynx, examination revealing nothing but a reddened and injected condition of the mucous membrane. The pharynx was swabbed out with a solution of tannin of the strength of 1 in 15. Immediately afterwards the mucous membrane became greatly swollen, the nostrils entirely occluded, an irritating watery fluid being secreted. The uvula and soft palate were found to have become œdematous, the former lying on the dorsum of the tongue. Ice was given to suck, and cold compresses were applied. About an hour later, the patient complained of a certain degree of stupor, and of a distressing general itching affecting the whole of the surface of the body, which presented the appearance of general urticaria. The next day this had disappeared, and the swelling of the nasal and pharyngeal mucous membrane had greatly diminished. The patient then mentioned that twice before he had suffered from almost exactly the same symptoms after being treated with tannin—once in the form of powder and once in that of solution. On one occasion he had been seized with severe lassitude and prostration, his "brain feeling quite empty," and he had noticed that his urine was quite dark on both occasions.—*Lancet*, Jan. 11, 1890.

Jackson (G. T.) on a Remarkable Case of Acute Poisoning from the External Use of the Tincture of Iodine.—Mrs. A——, about fifty years of age; Irish. General health is good. The patient is enormously fat, and the skin is fair, thin, and soft. She says that three days before coming into the hospital she had a pain in the right side of the abdomen, for the relief of which she had a little girl rub into her side "half of five cents' worth of iodine." This was done at nine o'clock in the evening. At one o'clock she awoke with a feeling of great nausea, and vomited six or seven times a yellow fluid that was very acid, so that it burnt her throat. The next morning she found that there was a good deal of redness of her right arm, and a large blister upon it. The dermatitis spread rapidly from here, and within twenty-four hours it had involved the face, neck, shoulders, left arm, and appeared in patches on the trunk. Then bullæ appeared on the legs, and in this condition she was admitted to the hospital.

When first seen by me, the eruption was evidently subsiding. The arms, face, neck, and trunk showed evidence of a lessening dermatitis, being red and scaly. The face was somewhat swollen, and there was a yellowish green crust on the right forearm. On both legs were a number of irregular-shaped figures with a red outline, which without doubt were the sites of the bullæ. There were also one or two bullæ with turbid contents. The tongue was greatly swollen, red, and glazed. The patient complained of a feeling of prostration, of great burning and discomfort in the skin, of complete anorexia, and pain, and burning at all attempts at deglutition. She also said that her throat and stomach felt raw.

She was ordered a strict milk diet, water *ad lib.*, an alkaline diuretic, and a mouth-wash of chlorate of potash. Locally it was directed that she be smeared over with vaseline, and powdered with corn-starch powder, two or three times a day. Under this plan of treatment she rapidly improved, as far as her skin was concerned, so that within two weeks there was only a slight erythema of the skin remaining.

The disturbance of her digestion was not so easily controlled. She was troubled with vomiting so that whatever she drank was returned in a short time. But within three weeks' time this all passed away, and she was discharged in good health.

In this case it is hard to believe that the profound constitutional disturbance was

not due to the patient having swallowed the iodine. But this she positively denies. If her statement is true, the case is certainly a remarkable instance of idiosyncrasy toward iodine.—*Med. Record*, July 12, 1890.

Beale (L. S.). Antifebrin Not a Safe Remedy.—The author thnks that antifebrin and more than one allied substance are not safe, and ought not to be prescribed. A high temperature, as far as he is able to judge, does less harm to the patient than some of the substances given to reduce it. The class of remedies in question occasions physiological changes which are indeed the very last to be desired in cases in which the tendency to death, particularly in certain forms of acute disease, is due to defective action of heart or lungs, or both, and is, in fact, contra-indicated.—*Lancet*, Feb. 15, 1890.

Dyer (E. E.) on a Case of Exalgine Poisoning.—A young man, A. J. M., aged twenty, had been suffering for some days from muscular rheumatism. I ordered a mixture containing exalgine gr. ijss. in each dose with tincture of orange and water, to be given three times a day (this dose of exalgine being rather larger than that given by Professor T. R. Fraser, of Edinburgh, but less than that given usually by Drs. Bardet and Dujardin-Beaumetz). The first dose was given about 3 P.M. I was prevented from seeing the patient until about 10 A.M. on the second day afterwards, so that he had taken six doses. I found him very dull and heavy, and apparently presenting all the usual signs of carbolic acid poisoning. He had slept almost continuously, but waking up at short intervals, and starting in his sleep. On inquiry he complained of pain in the small of the back, and on examining the urine it was found to be of a distinct and pronounced olive-green color. He had only passed water twice in the twenty-four hours, and on both occasions the amount was very small.

On examination, the urine was found to be of high specific gravity, with a large deposit of urates, but containing no phosphates, albumen, or blood; the temperature was 98.0° Fahr., pulse 102, of full volume and strong. The patient complained of great thirst, and the skin was hot and dry. A peculiar feature of the case was that he suffered from excessive salivation for several days; this gradually diminished under the influence of chlorate of potash. The renal trouble gradually subsided after stopping the exalgine and giving a diuretic and diaphoretic mixture, and the cerebral symptoms also passed off. I must remark that the exalgine certainly appeared to relieve the myalgia and rheumatism.—*Brit. Med. Jour.*, Aug. 30, 1890.

Fatal Poisoning with Salol.—Dr. Hesselbach reports, in the *Fortschritte der Medicin*, the case of a young man suffering with rheumatism, who took by mistake two drachms of salol. Coma resulted, with great dryness of the tongue, anuria, and death on the second day. At the necropsy the kidneys were found to be soft, anæmic, and of a pale-yellow color; microscopically, the glomeruli were full of embryonic cells and leucocytes, the convoluted tubes were tumefied, and fatty degeneration had begun. The tubuli were filled with degenerated epithelium. There were no other lesions attributable to the drug. The toxic principle was the carbolic acid that is generated from salol in the system; and the author believes that it should be prescribed carefully, and the condition of the kidneys, as indicated by the urine, carefully watched.—*N. Y. Med. Jour.*, Aug. 30, 1890.

Abbot (S. L.) on Cystitis Treated with Salol.—The author narrates three cases of cystitis in women in which, all other treatment failing, salol finally cured. It was given, as a general thing, in gr. x. doses t. i. d., or gr. v. doses every three hours. Under its use the urine became acid and bad symptoms rapidly disappeared.—*Boston Med. and Surg. Jour.*, July 17, 1890.

McShane (J. T.) on the Treatment of Carbuncle by Rhigolene.—In the treatment of a number of cases of carbuncle during the last four years I have used rhigolene as a means of producing local anæsthesia before making a crucia incision through the affected tissues.

I have observed that in those cases in which the tissues had been thoroughly frozen, free suppuration was established earlier than usual, and, consequently, the patients were cured earlier than usual.

An important desideratum in the treatment of carbuncle is to accelerate the suppurating and sloughing processes. After careful observation in eleven cases treated with the rhigolene spray, I am thoroughly convinced that the disintegrating process

is decidedly hurried by this mode of local treatment. The cellular tissues yield up the pus more readily after its application, and the pain, which is generally excruciating and long-continued, is less acute after the parts have been well frozen. I claim, therefore, that by this treatment the patient is spared the loss of considerable valuable time, and that he is also relieved of much suffering. To obtain the best results it is necessary that the parts be deeply frozen. This is accomplished by allowing the spray to play slowly on the affected parts so that about two minutes may be consumed in this part of the operation. This secures almost absolute freedom from pain during the operation of incising the parts, and the loss of blood is insignificant in amount.

Warm poultices locally, and constitutional treatment as may be required in each case, must not be overlooked.—*Med. Mirror*, July, 1890.

MEDICINE AND PATHOLOGY.

Koch (R.) on Immunity against Tuberculosis.—The author thinks we are on the eve of practical therapeutic developments based upon bacteriology. He has not only succeeded in conferring upon guinea-pigs, which are known to be peculiarly susceptible to tuberculosis, perfect immunity against that disease, but has also discovered means of arresting the growth and multiplication of tubercle bacilli after inoculation. If he should be equally successful in preventing and arresting tuberculosis in man, it were not too much to hope that means would be found for successfully combating other diseases. —*Med. Record*, Aug. 9, 1890.

New Treatment of Tuberculosis by the Vaccine Method.—On November 19th last Drs. J. Grancher and St. Martin addressed to the Académie de Médecine a sealed packet relating to a method of treatment and preventive inoculation of tuberculosis based upon numerous experiments which they had made on rabbits. The communication made by Dr. Koch to the Berlin Congress (of which the full text was published in the *Brit. Med. Jour.* of August 16th), concerning the results which he has obtained in rendering guinea-pigs refractory to tuberculosis, or in curing them of advanced forms of tuberculosis, has induced MM. Grancher and St. Martin to make known their researches on the same subject earlier than they would otherwise have done. In all these experiments they chose the rabbit as the subject of inoculation and intravenous injection, because there is thus produced a tuberculosis which kills very quickly, and at an almost fixed date, with constant lesions of the liver, the spleen, and the lungs, and which defies all local treatment. Tuberculosis thus induced being always fatal, a solid basis is thus secured which allows exact appreciation of the negative or positive results of any method which tends to produce the refractory state or to cure after infection. The method employed by MM. Grancher and St. Martin was the injection of tuberculosis cultures attenuated in various degrees, and used like the dried spinal marrow in Pasteur's treatment of rabies and hydrophobia. Nine degrees of attenuation have been obtained, the four last being such that the cultivations remained sterile. The injections were made first with the most attenuated cultivations, and then with more and more virulent ones. The authors consider that by this method they have succeeded, on the one hand, in conferring on rabbits prolonged resisting power against the most certain and the most rapid experimental tuberculosis, and, on the other hand, in conferring an immunity against that disease, the duration of which remains to be determined.—*Brit. Med. Jour.*, Aug. 30, 1890.

Experimental Infection with Milk from Tuberculous Cows.—Dr. Karl Hirschberger has made, at the request of Dr. Bollinger, a series of experiments in the Pathological Institute at Munich on the inoculation of animals with milk from cows in various stages of tuberculosis. He attempts to answer the following questions: 1. Do tuberculous cows frequently give infectious milk, or is their milk only exceptionally infectious? 2. In which forms of tuberculosis is the milk infectious—in localized, or only in general tuberculosis? He made twenty experiments, and calls attention to the fact that inoculation alone can give decisive results, because it is very difficult to observe tubercle bacilli microscopically in the milk, and impossible to discover their spores. On the strength of his experiments he states that the danger of infection from the milk of tuberculous

cows does not only exist, but is very great, being found in 55 per cent. of all cases examined. The more the tuberculosis has spread the greater is this danger; but even in mild cases of localized tuberculosis the milk is, he considers, more or less infectious.—*Lancet*, Aug. 30, 1890.

Abbott on Milk as a Culture Medium for the Tubercle Bacillus.—My experiments with milk demonstrate that the organism not only retains its vitality in milk, but may increase and multiply to an extent quite equal to that seen when other artificial media are employed.

In these investigations ordinary milk as it comes from the shops was employed. No attention was paid to its reaction. As the organism apparently grows best when exposed to oxygen, it was, of course, necessary that some agent which would render the milk solid should be added. For this purpose agar-agar, which of itself offers no nidus for the growth of the organism, was added to the milk in the proportion of 1 per cent. The whole was then sterilized and placed in tubes, and allowed to solidify in the way commonly employed for blood-serum tubes. The tubes of solidified milk were then inoculated from a pure culture of the organism, and then placed at the temperature of the body (37.5 ° C.). After the usual time growth began, and progressed in as favorable a way as one ordinarily sees in this organism.

The conclusion, then, from these experiments, in connection with the results of other observers, is that the milk of these cattle not only may contain the tubercle bacillus, but that the organism retains its vitality, and may even increase and multiply in numbers, under favorable conditions. With few exceptions, in this country, the use of uncooked milk is the rule, and there can hardly be any doubt that a certain amount of infection takes place in this way. The evidence in hand certainly contra-indicates the practice and suggests some remedial steps.

The sterilization of milk for domestic use is a simple matter, and should be insisted upon. It may be accomplished in two ways: by boiling and by steaming. The latter is the preferable method, as it causes less alteration in the milk. It may be accomplished as follows: Place the milk to be used in a clean flask, or in several flasks, depending upon the quantity needed; plug the mouths of the bottles with raw cotton, and steam, in the ordinary steamer found in every kitchen, for a period of not less than thirty minutes, the time to be reckoned from the beginning of boiling. By following the directions carefully the organism will be rendered inert, and a step in the prophylaxis of the disease will be accomplished. When one considers that one seventh of all deaths are from tuberculosis it certainly seems incumbent upon us to take all measures in our reach to try and lessen this proportion.—*Johns Hopkins Bulletin*, May, 1890.

Sternberg (G. M.) on Cocoa-Nut Water as a Culture Fluid.—The fluid contained in unripe cocoa-nuts is known in the West Indies as *agua coco*, or cocoa-nut water. Unlike the fluid contained in the ripe nut, which has a milky appearance, it is perfectly transparent.

At the time of my first visit to Cuba, in 1879, the idea occurred to me that this fluid might be a useful culture-medium for bacteria, and upon making the experiment I found that various species grew in it most luxuriantly.

As it is contained in a germ-proof receptacle no sterilization of the fluid is required when it is transferred with proper precautions to sterilized test-tubes, or is drawn directly from the nut into the little flask with a long and slender neck, which I am in the habit of using for fluid cultures. In these it may be preserved indefinitely, remaining perfectly transparent and ready for use. Heating the fluid causes a slight precipitate.

In the investigations which I have made in Havana during the past two years I used this fluid very extensively and found it a great convenience to have a sterile culture-fluid always at hand ready for use at a moment's notice. Moreover, it has certain special advantages for the study of the physiological characters of various bacteria and for the differentiation of species. It contains in solution about four per cent. of glucose in addition to vegetable albumin and salts, which alone would make it a useful nutrient medium.

Certain micro-organisms multiply in it without appropriating the glucose, while others split this up, producing an abundant evolution of carbonic acid, and giving to the fluid a very acid reaction. As obtained from the nut it has a slightly acid reaction, which makes it unsuitable as a culture-medium for certain pathogenic bacteria,

but when desired it is a simple matter to neutralize it. For a large number of species of bacteria and for the saccharomycetes it constitutes a very favorable medium. —*Med. News*, Sept. 13, 1890.

Anders (J. M.). Is Pleurisy in Children Tubercular?—Among children over two years of age pleurisy is a disease of common occurrence. It may be safely stated that, as a rule, the complaint is not immediately fatal, although the danger of its leading to other forms of serious disease is generally conceded. Professional opinion is divided as to whether or not this disease is of tubercular nature. The writer presents the notes of five cases which have come under his own observation. Although the author from his own experience with pleurisy occurring in the adult, is in agreement with those authorities who contend, more especially, that long-standing empyema is very apt to lead to the development of tuberculosis; yet it is seen in all of his five cases of pleurisy with effusion occurring in children that recovery was complete, and that none of these patients developed the slightest phthisical manifestations. It appears to him that it would be quite unjustifiable to attribute any manifestations of phthisis that might be developed in these subjects in the future to the original attacks of pleurisy or empyema, and this for the reason before intimated, that not the slightest evidence of tuberculosis in any organ of the body has been exhibited from the time of full recovery to the present writing, a period of time ranging from four to ten years. To attribute a case of tuberculosis to an attack of bronchitis, from which the person may have suffered and recovered five years previously, would be quite as warrantable. Rheumatic pleurisy also occurs both as a primary and a secondary affection. The author, however, has no intention of denying that in children pleurisy is frequently associated with generalized tuberculosis.—*Arch. of Pediatrics*, May, 1890. E. S. B.

Foxwell on Chronic Phthisis with Unusual Dislocation of the Heart.—The patient was a man, aged twenty-one, with unusual dislocation of the heart. There were the usual evidences of advanced fibroid phthisis of the left lung, the amount of disease at the base being extreme. He had had a cough for four years, with debility, but had not been obliged to give up his work as an iron-turner. The absolute cardiac dulness towards the right did not reach the left edge of the sternum by an inch. The apex beat was in the fifth space, and an inch to the left of the left nipple line. There was thus not merely a displacement of the heart by the tilting of the apex upwards and outwards, but a dislocation of the heart *en masse* for more than an inch towards the left side. These signs were not due to the overlapping of a dilated heart by a hypertrophied right lung: 1, because the right lung retreated to the left edge of the sternum above the fourth cartilage (which was the level of upper cardiac dulness in the case); 2, because there was no evidence of cardiac enlargement, either from the sounds or the symptoms; 3, because the præcordium was markedly flattened and retracted, as well as the whole of the base of the left chest. Another interesting point was the prominence and rigidity of the eighth, ninth, tenth, and eleventh dorsal spines, though there was no evidence of any disease of the vertebræ. This condition the patient had noticed for one year, and Dr. Foxwell concluded it was due to the pleural and peripleural thickening which had occurred during the course of the fibroid phthisis. A similar result had taken place in the case of a young girl whom he had shown to the society a month previously, with a spine rigid from inflammatory thickening, which had arisen in the course of an empyema of several years' duration.—*Brit. Med. Jour.*, March 29, 1890.

Kimmel (J. A.) on Milk Sickness.—Milk sickness is a peculiar disease met with in the Central Western States of the Union. The cause of the disease is not known, but it seems to prevail in parts of the country newly opened up to settlement, and to disappear from those where the soil has been brought to a high state of cultivation. Animals seem to be more liable to contract the disease when they pasture late at night or early in the morning. The affected animals usually remain immovably in one place, or wander around over a limited area slowly, and holding the head close to the ground. The appetite disappears, and obstinate constipation is the rule. A little later the animals begin to tremble, and this continues for three or four days, at the end of which time they usually die, although the disease is not invariably fatal. Oxen and bulls only are affected, cows

being immune as long as they give milk. The virus of the disease is apparently eliminated through the mammary glands, for the disease is contracted by men and other animals that drink the milk coming from cows in an infected herd. The symptoms of the disease in man are very constant, and the diagnosis, as a rule, is an easy matter. The first symptom is a feeling of great fatigue, a languor which the patient, no matter how active he may be by nature, is wholly unable to overcome. Following this are anorexia, nausea and vomiting, pyrosis, and obstinate constipation. Excessive thirst is a prominent symptom. There is no elevation of temperature, indeed the latter may even be subnormal, and the pulse is usually unchanged. The skin is dry, tongue moist and coated at the tip. Respiration is difficult and sighing. The thirst is intolerable, but every drop of water that is swallowed is immediately rejected. The abdomen is retracted but is not tender on pressure. Delirium is rarely observed. Little by little the prostration becomes more marked, the patient can move neither hand nor foot, even the eyelids become immovable, and finally the patient dies in coma. The duration of fatal cases is from fifteen to twenty days, as a rule, but when recovery takes place it usually does so in from five to ten days, but convalescence is apt to be very prolonged and tedious. Milk sickness is clearly distinguished from typhoid fever, malarial affections, and gastro-enteritis by the entire absence of fever. It is possible, however, to have malarial fever exist as a complication, and then, of course, pyrexia would be present. The treatment usually employed consists in the administration of quinine, alcohol, and other stimulants. The disease in man can in almost every instance be traced to the use of milk, or butter made from it, coming from a cow pasturing with other infected cattle. The pathogenic micro-organism of the disease, if such exist, has never been isolated, but Dr. Kimmel believed that the disease was of microbial origin, and that the infecting parasite was similar to that of malaria, since the disease is cattle was contracted in a manner very similar to that of malaria in man.—*Med. Record*, Sept. 13, 1890.

Gualdi on Malarial Inoculation.—Ever since Gerhardt first produced typical intermittent fever in the human being by the direct transfusion of a little blood taken from a malarial patient, similar observations have been from time to time recorded. Recently Dr. Gualdi, working under the supervision of Professor Bacelli, of Rome, has instituted a new series of investigations touching the subject of malarial inoculation. It was found that the blood of a malarial patient injected into the veins of a healthy subject invariably produced paludal infection. The quantity of blood used for each injection was small, and did not exceed sixteen minims. It was further ascertained that the incubation period did not vary, and lasted just twelve days.

An interesting circumstance was also noted in the fact that the precise type of the patient's disease was reproduced in the inoculated persons. That is to say, if blood was taken from a patient suffering from quotidian ague the inoculated subject would develop quotidian intermittent fever; if quartan, a quartan type would follow; a tertian fever always induced tertian ague, etc.

The blood of an inoculated person invariably showed the presence of the plasmodium described by Marchiafava and Celli, and what is more, the stage of evolution of the plasmodes corresponds to the type of the disease.

Dr. Gualdi asserts that the crescentic bodies known as Laveran's plasmodes, which have been repeatedly found in the red blood-corpuscles by different observers, represent but a late stage in the development of the Marchiafava and Celli organism. If this be true it would harmonize in a plausible manner the hitherto somewhat conflicting claims of these Italian authors. The parasitic nature of the plasmodes admits of no doubt, according to Gualdi.—*Med. Record*, Aug. 30, 1890.

Ruffer (A.) on the Destruction of Micro-Organisms by Amœboid Cells.—With reference to the germ of diphtheria, the author concludes:

1. The bacilli of diphtheria are present in the most superficial part of the membrane only, that is, in a place where they are well within reach of medicinal agents, an observation not without interest from the point of view of treatment.

2. In the diphtheritic membranes there is an active struggle taking place between the amœboid cells in the membrane and the micro-organisms. In other words, the diphtheritic membrane is a battle-field for amœboid cells and the pathogenic microbes of diphtheria.

3. The reason why the bacilli do not actually penetrate into the tissues is probably that, as soon as they try to do so, they are arrested by the amœboid cells present in the diphtheritic membrane.—*Brit. Med. Jour.*, Aug. 30, 1890.

Vaughan (V. C.) on Some New Bacterial Poisons; their Causal Relation to Disease and the Changes in our Theories Suggested by their Action.—The author sums up the present state of our knowledge on the above subject as follows:

1. Man is attacked by the infectious disease either through the alimentary canal or through the blood or lymph.

2. The gastric juice is a physiological guard against infection by the way of the intestines.

3. Additional guards against infection by the intestines are probably to be found in the absorbing cells of the stomach and intestines.

4. Susceptibility to the intestinal infectious diseases is increased when for any cause these physiological guards are defective.

5. All toxicogenic germs are dangerous when introduced into the intestines, and their capability of doing injury lies in their production of chemical poisons.

6. Many of these poisons are proteid in character.

7. These poisonous proteids most probably act by catalysis.

8. In the splitting up of complex molecules into simpler ones, heat is liberated and fever manifests itself.

9. The physiological guard against infection through the blood or lymph lies in the germicidal action of the proteids of these fluids.

10. Susceptibility to infection through the blood or lymph is increased by impoverishment of these fluids.

11. We can continue to treat consumption and other systemic diseases by the employment of liberal diet, exercise in the open air, and constitutional remedies without being unscientific in our practice.

12. Filth, without being the bearer of a specific germ, is a cause of disease.

13. Wherever man pollutes the soil about him, the air which he breathes, and the water which he drinks with his own excretions, there enteric fever will be found.

14. In their causal relation to disease, germs cannot be classified without a knowledge of the chemical changes which they induce.

15. While certain bacterial poisons can result only from the growth of certain germs, other poisons similar to one another in their action, though probably not identical, may result from any one of a number of organisms. In the former case we have such diseases as anthrax and small-pox, with their practically constant symptoms and well-marked course; in the latter case we have such diseases as the summer diarrhœa of infancy and enteric fever, with their varying symptoms.—*Med. News*, Aug. 16, 1890.

Horsley (V.) and Semon on Motor Nerve Supply of Larynx.—The authors gave a demonstration on their work on the motor-nerve supply of the larynx in the cat and in the dog. This was done by means of a lantern and screen. The central nervous system being exposed in the animal, and the trachea being cut through well below the cords, into the lower half of the trachea a tube for artificial respiration was introduced, and the lower end of divided upper part being drawn forward. At the same time, the mouth being fixed widely open, and the tongue drawn well forward, the light from a lantern being directed into the fauces, all the movements of the cords were represented on the screen. As the result of their experiments, the authors had been able to localize an adductor centre on the cortex in both cat and dog, but stimulation of the centre in the dog, corresponding to the abductor centre in the cat, produced only slowing and intensification of the movements. Also that one-sided irritation produces double-sided movements. From this it follows that a one-sided paralysis of the cords as the result of a lesion of the cerebral hemispheres does not exist, and also that motor aphasia is not identical with aphonia. On account of the prostration of the animal experimented on, they were on this occasion unable to demonstrate satisfactorily that the adductor fibres could be stimulated in the external capsule, and that closure of the larynx could be produced by stimulation when the whole of the hemispheres were removed. Dr. Anodi (Budapesth), states that, after section of the recurrent laryngeal nerve, the branches which go to the abductors die before those which supply the adductors. Professor

Dubois-Reymond (Berlin) states that in some animals, such as the cat and cow, phonation was by means of inspiration, and not by expiration.—*Brit. Med. Jour.*, Aug. 16, 1890.

Krause (F.) on the Central Motor Innervation of the Larynx.—The author calls attention to the fact that the results of the researches of Semon and Horsley, which have recently been published in preliminary form, coincide almost completely with his own conclusions based on investigations suggested by Prof. F. Munk. To the latter belongs the credit of having mapped out with accuracy an area on the surface of the cerebral cortex which presides over the vocal mechanism.—*Brit. Med. Jour.*, Jan. 18, 1890.

Minor (J. O.) on Epistaxis in Liver Trouble.—I report six cases, two of long standing, of obstinate epistaxis; the usual symptoms of the bilious disorders, frequently accompanied by malarial troubles existing. In all of these cases hot douches, lemon-juice, tannin, ergot, etc., were used, proving of no value except in two cases, the other four yielding promptly after irritating the region of the liver with a blister or yellow oxide of mercury ointment. On return of the malarial symptoms in two of the cases, the tendency to hemorrhage returned, but was easily controlled by the application of the yellow ointment to the right hypochondrium.

I have had for several months under my treatment a girl nine years old, apparently bright, cheerful, and in good health, but who has been since early infancy subject to periodical attacks of epistaxis. The attacks have been usually protracted and prostrating, occurring about every two weeks, lasting sometimes four or five days, and suddenly ceasing. About three months ago I prescribed during a severe attack, unguentum oxidi hydr. flav., to be rubbed over region of liver and spleen, and directed its continued application night and morning for several days. Tinc. ferri chlor. was also administered during one afternoon, every two hours, in twenty-drop doses. The bleeding ceased in four hours. Considerable irritation resulted from the use of the ointment. She has since had but one attack, which lasted only a few hours. The ointment is used occasionally in her case as a precautionary measure.

We rarely see cases of obstinate epistaxis, unless there is some want of vitality present, with an atonic condition of the capillaries. Many such cases are due to disorders of liver and spleen of malarial origin. I found enlargement of liver and spleen in all of these cases.—*New Orleans Med. and Surg. Jour.*, Sept., 1890.

White (F. S.) on a Remarkable Suicide.—A male of thirty-five had had melancholia with delusions of persecution for seven months. Two weeks ago he had so far recovered that preparations were being made to send him home, but the excitement incident to going home overbalanced his mind again, and the same delusions returned and were now more intense.

On May 16th he was outside in the grounds with the other patients, when a sudden impulse to destroy himself seized him, and without any warning he ran, head foremost, against a tree from a distance of about twenty feet. He fell perfectly limp and senseless to the ground. I saw him in about five minutes; found him wholly unconscious, pulse slow, about forty-five, respiration slowed, pupils contracted, could not swallow. Had not, up to this time, moved a single muscle since the injury.

In half an hour I again examined him; found some reaction, pulse now about fifty, and respiration fifteen; pupils not so closely contracted, some motion in upper extremities, and he could now swallow. No motion or sensation from about the sixth rib downward. Very little sensation in forearm; could not talk or answer questions intelligently. Breathing was abdominal; sensation normal in face and neck; he could move his head but complained of pain in his neck. I did not examine his neck very closely but examined the head at seat of injury and found no indication of fracture whatever. He remained unchanged for twelve hours, when there was considerable reaction; pulse increased to sixty and respiration to sixteen, pupils nearer normal but still contracted. He rested better on the side, still, while being moved he complained of pain in neck and back, also said he had headache. Fæces and urine were retained. In two days there was a slight rise in temperature and looseness of the bowels. On the fourth day after the injury there were contractions of the muscles of the face and arms, the breathing became more rapid, the pulse weaker, and death ensued.

An autopsy revealed a small blood clot

on the upper surface of the cerebellum, fracture of the fifth and sixth cervical vertebræ, with pressure on and consequent softening of the cord at this point.—*Daniel's Texas Med. Jour.*, Aug., 1890.

Thorburn (W.) on Disease of the Breast in the Male.—The author describes a tumor which he had removed from the right breast of a boy aged eleven. The growth had been noticed twelve months previously, and was then the size of a hazel-nut, but when first seen it was as large as a small orange, and of the shape and consistency of the ordinary female breast. Some pain was felt in the region of the growth and down the arm. No fluid could be pressed out of the nipple. No cause could be found, except that the boy leaned against the breast while writing. There were no signs of inflammation. The testes and penis were normal, and the face by no means effeminate. On removal, the mass was found to consist of fibrous tissue, with a few ducts lined by a columnar epithelium, and almost devoid of lumen. He also describes a scirrhus of typical structure removed in 1886 by Mr. F. A. Heath from the left breast of a man aged fifty-five. The growth, which was about double the size of a walnut, had been noticed for twelve months, and the axillary glands were not supposed to be affected. No cause for its appearance could be assigned.—*Br. Med. Jour.*, Feb. 1, 1890.

Tertiary Syphilis of the Mamma.—Muriac has recently discussed the subject of tertiary syphilis attacking the mamma, and remarks upon the extreme rarity of the lesion. Syphilis shows itself in the organ in two forms, either in that of infiltration or as a gummatous swelling. Syphilitic infiltration of the mamma is met with in both sexes; though it is, perhaps, more frequent in the male than in the female. The lesion generally makes its appearance towards the end of the secondary stage—without any signs of active inflammatory changes. Specific treatment quickly disposes of it. Gummata or gummatous ulcerations constitute true tertiary syphilis of these organs. This variety of the disease is more commonly seen in the male than in the female. The gummata begin as small swellings concealed in the substance of the breast, and distinctly circumscribed. They may be mistaken for glandular growths; by degrees they increase in size, reaching ultimately that of an apple, an egg, or even that of a fœtal head (Sauvage). They are hard to the feel, uneven on the surface, somewhat nodular, until they reach the integument. Then they begin to soften and to fluctuate. When the swelling is opened lactescent matter escapes, and soon a deep ulcerated cavity occupies the situation of the gumma. The diagnosis is usually not difficult as to the nature of the swelling, especially if due importance is assigned to a trustworthy history. In the ulceration stage the lesion might be confounded with malignant disease in the absence of a clear history of syphilis. There are, however, certain points of use in arriving at a differential diagnosis. Gummata are often bilateral and multiple, while multiple malignant growths or the simultaneous appearance of cancer in both breasts would be of extreme rarity. In gummata of the breast, also, there is sometimes some enlargement of the axillary glands, but this is much less pronounced, less hard, less extensive, than that associated with cancer. In doubtful cases specific remedies will always clear up the diagnosis. In several cases cited by the author the iodide of potassium brought about a satisfactory result even when the resemblance of the ulceration to cancer was such that removal of the disease had been suggested.—*Med. Press*, July 9, 1890.

Infrequency of Syphilis in English Country Practice.—Alfred Freer, President of the Birmingham and Midland Counties Branch of the British Medical Society, in a presidential address, speaks as follows of his experience:

"I am old enough to remember M. Ricord's instructive and oft amusing lectures under the trees of the garden at the Hôpital du Midi, when he used to operate *sub die* early in the morning. At that time one could not help looking at the world through a syphilized atmosphere, and when I came to country practice I found plenty of examples of the old scourge; but for many years past I have seen less and less of syphilis, so I suppose the nymph is beginning to take up residence more exclusively in cities and large towns; or perhaps she is shy of appearing before greybeards. Her prime exhibit, the true Hunterian chancre, on which the great Ricord used to expatiate so eloquently, has almost gone from my gaze. It is a matter for national congratulation that, owing to the improvements in habits of cleanliness among the people, if not to improved morality, this disease is

far less virulent than formerly, even in our large centres."—*Boston Med. and Surg. Jour.*, Sept. 4, 1890.

Hadra (B. E.) on Tetanus Due to Direct Infection.—"On Jan. 7th, a car-driver was admitted with a compound fracture of the leg. The soft parts as well as the bones were badly crushed, so that an amputation seemed advisable; the patient, though, would not consent to my proposition. Under appropriate treatment he did well enough, and in spite of delirium potatorum the case appeared hopeful. An extraordinary quick pulse, however, contrasting greatly with the nearly normal temperature, kept me on the outlook for a coming storm. On the 22d slight trismus set in, and on the 24th the patient died from tetanus. It has to be added that he received his injuries by being thrown from his seat while driving a street-car, and that the wheels passed over his leg. His clothes were so torn that, no doubt, the hind wheels had ample opportunity to deposit their dirt upon the wound.

"On the 22d of the same month a negress was sent to the hospital suffering from cancer of the breast, the ward she was admitted to being in another building from the one in which was the former patient. She was operated upon on the 23d, by removal of the breast and the axillary glands, with all their surrounding padding. The wound was stitched up, and a drain left only for the axilla. It is hardly necessary to state that the operation was done under aseptic precautions. Healing throughout by first intention followed, except in the track of the drainage-tube, and she would have left the hospital but for the money she waited for, to pay her voyage home. The drain, which had been clipped from time to time, was removed by the Interne on the 3d of February, and its shallow and healthy-looking track was superficially dressed. All was virtually healed when, to our surprise, on the 5th tetanus set in, to which patient succumbed on the 10th.

"Our two cases occurred in different buildings, but the same Interne had charge of both and had dressed them both with the very same instruments. The latter were not as thoroughly disinfected after each dressing as to make the pathogenic virus innocuous, and without casting any blame on the much-worked dresser, I nevertheless consider him the carrier of the deadly poison. The time of incubation—fifteen days—corresponds fully with the second infection." The author advises that simple cheap dressing instruments be designated to each bed, to be used only on one patient, and disinfected at leisure.—*Kansas City Med. Index*, Aug., 1890.

Effects of Castration in the Female.—The following experience of a veterinary surgeon is of interest in relation to complete removal of the ovaries in our own species. M. Barthelemy states in the *Journal de Médecine Vétérinaire* that œstrum or "rut" can occur in pigs after complete removal of the ovaries. A professional spayer operated on thirty-eight young pigs under 60 days old, yet these animals showed the symptoms of "rut" at from 3 to 8 months, and monthly after that age, as though they had not been spayed. An action was brought against him after M. Barthelemy had given his opinion that the œstrum indicated incomplete removal of the ovaries. The defendant declared that he had seen œstrum in pigs which had been properly spayed. The court ordered that five of the pigs that showed all the phenomena of œstrum to the greatest extent should be killed and examined by a competent veterinary surgeon. This was done, and it was found that in each case the operation had been well performed, the ovaries, tubes, and almost the entire cornua of the uterus having been removed.—*Brit. Med. Jour.*, Aug. 23, 1890.

Vanderveer (A.). She "Thought It was Change of Life."—After reporting the histories of cases of uterine polypus, cancer of uterus, inversion of uterus, and of subperitoneal fibroma, the author concludes as follows:

"These cases are to be found all over the country, and in some way we should indicate to our patients the importance of their yielding to a more prompt examination, when such histories as are here given are present. Our young women should be taught in our schools, academies, and colleges more on the subject of menstruation. They should know more about their reproductive organs from chaste, moral, and intelligent teachers. Mothers should know more of the functions of their own individual organs, and learn to teach their daughters.

Finally, the profession should exercise more care in impressing upon young wives and mothers the knowledge that in so many

cases they so sadly need, and not assume the care of patients who are so unwilling to have the necessary examination made." —*Jour. Am. Med. Assn.*, July 5, 1890.

J. S. H.

Milk Secretion in the Newly-Born.—According to the observations of Dr. Variot, all infants, male as well as female, secrete a certain quantity of milk soon after birth. This usually attains its maximum during the second week where the mammary glands are prominent, the skin covering them is of a pink hue, and pressure causes pain. He observes that abscess of the breast is almost as frequent in infants as with nurses, a rather startling statement which the experience of everyday practice hardly bears out. Before the eighth and after the fifteenth day the liquid is serous rather than milky, and in this form the secretion may be prolonged as late as the fourth or fifth month. This observer failed to detect an analogous condition among the young mammifera of other species.—*Med. Press*, Aug. 13, 1890.

A Child Born with Measles.—Dr. Lomer of Hamburg mentions (*Centralblatt für Gynäkologie*) a case of a child born with measles. The mother—an unmarried woman who had not had measles in childhood—was seized during a measles empidemic on June 7th with a rigor, cough, hoarseness, smarting of the eyes, and diarrhœa. The next day the pains of labor commenced—some five weeks before term,—and the child was born that evening. The next morning the mother was covered with a well-marked eruption of measles, and the child presented some dark spots on forehead and buttocks. The mother was attacked by pneumonia on the fifth day, and made a slow recovery; the child died when a month old from intestinal catarrh, its death being hastened probably by want of attention, and having probably nothing to do with the measles. The occurrence of measles at the time of childbirth is not commonly described in medical literature, therefore this case is of some interest.—*Lancet*, Jan., 4, 1890.

Cardiolith in a Child of Five.—Dr. Delepine describes cardiolith from a female child five years old, who had died from diphtheria. The stone was three quarters of an inch long, and a quarter of an inch broad, its inner surface being in contact with the tricuspid valve, and it consisted of carbonate and phosphate of lime, endothelial elements, fibrin, and probably hæmatin. It consisted really of a partially calcified cardiac thrombus or polypus. On the ground of its structure, appearance, and probable nature of its growth, the term cardiolith was proposed as a better one than either cardiac calculus or concretion. —*Med. Press*, Jan. 15, 1890.

Wallace (T. C.) on Dry Gangrene in a Child.[1]—The author's case was a girl of twenty months, and the attack came on during convalescence from the measles. The gangrene was limited to the toes and heel of the right foot.

The author refers to two other cases, one fatal, in which gangrene followed measles in very young children. In another case, reported by Dr. Nickerson, of Meriden, Conn., the gangrene occurred during the convalescence from severe remittent fever.—*Med. Record*, Aug. 9, 1890.

Early Maternity.—Dr. T. B. Nichols, of Plattsburg, N. Y., writes: "In a woodchopper's shanty, in the winter of 1855, dwelt two brothers, French Canadians, whose wives, also French Canadians, were sisters. That winter was not half passed when the writer was called to attend the youngest one in childbirth. The labor was normal and of short duration. The child was a plump six-pounder, and healthy in every respect. As the doctor was gathering up his hat and things to leave, the brother-in-law asked, 'Say, doctor, how old do you think that little mother is?' 'I should say about fifteen years.' 'No, sir,' said he, 'she is not thirteen yet.' And I can add that among that class of people in those days early maternity was not an uncommon occurrence."—*Med. Record*, June 28. 1890.

Harris (W. J.) on Early Pregnancy.—I was asked to attend the wife of a tramcar conductor in her fifth labor. She was a very short and stout woman twenty years of age. She had an easy delivery at full time of a healthy, well-developed male child. She informed me that she had been married before she was quite thirteen years old, out in Australia, to her present husband, and that she was a mother before she had completed her fourteenth birthday. This was her fifth child. All the children had been born at full time. Two of her five children she had lost in their second year—one evidently from tu-

[1] MEDICAL ANALECTIC, July, 1890, p. 309.

bercular meningitis, and the other from tabes mesenterica. The other children are still living.—*Lancet*, Jan. 25, 1890.

Hirst (B. C.) on Total Prolapse of the Uterus in a Young Nullipara.—A. S., aged seventeen, gives the history that while doing housework as a servant, when only eleven years old, she attempted to lift a heavy weight, and, as she expresses it, "so strained herself that her womb began to fall down." The prolapse thus begun got gradually worse until it became complete, when the child was about fourteen. Upon close questioning, it farther appeared that the girl had led the life of a prostitute from her eleventh year. She had been in the habit of replacing her womb and keeping it in place with large wads of newspaper and had thus gone about with comparative comfort. The case was treated by performing a complete anterior colporrhaphy with sunken catgut sutures and doing a posterior colporrhaphy somewhat after the manner of Emmet. Both wounds united perfectly, and the uterus appears to be firmly supported in a good position high up within the pelvic cavity.—*University Med. Mag.*, Feb., 1890.

Herman on Amenorrhœa from Mental Shock.—The author narrates several cases in which shock was supposed to have caused the cessation, but in which, he believed, the real condition was one of mental depression, akin to melancholia, and of defective nutrition, the amenorrhœa being beneficial rather than otherwise. The uterus showed either some atrophy or no change. In these cases the Weir Mitchell treatment, massage, and galvanism generally resulted in re-establishment of the function. Those who could obtain change of air, with exercise, food, and tonics, attained a like result. He saw no advantage in local treatment. He would ask, finally, whether there were any cases due strictly to mental shock unaccompanied by melancholic symptoms? Amenorrhœa was the rule in melancholia, and the cases he had described occupied, as it were, a half-way house to this disease.—*Lancet*, May 10, 1890.

Thornton (P.) on Twenty-Seven Epileptic Convulsions after Labor; Recovery.—A woman of twenty-four, on April 10th, 1890, was admitted into Canterbury Jail, with a sentence of two months' imprisonment. She was in good health, but both tibiæ were very rachitic, so that she was only four feet one and three quarter inches in height. This woman was confined of a full-time male child on May 13th, at 2:15 A.M., the labor lasting a little more than an hour. She said she had once previously had a child. During the labor she complained of intense headache, which did not leave her after the child was born, though it was rather less severe. Five hours and a quarter after the labor she had an epileptic fit, and between this time (7:30 A.M.) and 8:15 A.M. on the following morning she had twenty-seven seizures. She was unconscious throughout, remaining so after the fits had ceased until 5 A.M. on the 15th. From this date she made an uninterrupted recovery, but for some days was unable to take solid food, her tongue having been severely bitten during the attacks. On her discharge from the prison, on June 10th, she was able to carry her infant to the station. "My first treatment was bromide of potassium, but as it was found impossible to administer this medicine, I put the woman under chloroform. Not being able to continue its administration, I ordered drop doses of 1 per cent. nitro-glycerine every hour. This treatment was begun at 1 P.M. on the 13th, and was carried on until 5 P.M. It was recommenced at 10 P.M., and from that time was given every hour until the cessation of the fits. It was then administered less frequently until twenty doses in all had been taken. During the time this treatment was being carried out the matron of the prison remarked to me that she felt sure the medicine had good effect, that, though it did not lessen the violence of the fits, it evidently affected the length of time between them. Feeling sure that the woman had albuminuria, and being very much occupied at the time, and not expecting her recovery, I did not make any examination of the urine. There was no albumen in the woman's urine shortly before her discharge from the prison. During the time of the convulsions I once gave chloroform to enable the bed linen to be changed.—*Lancet*, July 5, 1890.

Mendel on a Case of Lethargy.—The patient was a tramway driver of nineteen, a strong and healthy lad, who had never been seriously ill in his life. While he was driving a car last November a weariness suddenly came over him without any warning symptoms, and he felt as if in a dream. He drove on mechanically, and,

as the horses stopped and went off of their own accord on hearing the conductor's bell, his condition was not at once noticed. On the second day, however, he seriously damaged two carriages and imperilled a third, and did not notice them until the collision had occurred. He was now suspended from service and medically examined; but the doctor found nothing the matter with him. This condition lasted five days, during which he ate only when told to do so, took all that was given him, and was so helpless that, as he himself expressed it, anybody might have done what he liked with him. This lethargy ceased as suddenly as it had begun. Having been dismissed from the service of the tramway company, he had to look out for other employment, and was working in excellent health and spirits at a building on Dec. 2d when the same lethargy came over him again. This time, too, he worked on mechanically, only with the difference that he did not speak. The somnolent condition lasted six days, and then ceased as suddenly as before. It is a nervous affection, the causes of which are still unknown. Experience, however, has sufficiently proved that it is not dangerous.—*Lancet*, Feb. 1, 1890.

Manton (W. P.) on Sudden Emptying of the Bladder as a Cause of Cystorrhagia. — The cases briefly reported by the author are not only interesting on account of their rarity, but instructive, teaching us that:

Over-distention of the bladder may result in tissue or other changes which predispose to hemorrhage.

Sudden emptying of the distended viscus may precipitate rupture of the vessels, and ultimately result in death.

The urine should be withdrawn at intervals in small amounts, in order that the bladder may accommodate itself to the new conditions.—*Am. Lancet*, Feb., 1890.

Knight (C. H.) on a Case of Hemi-Glossitis Phlegmonosa.—This seems to have been a case of what has been called by Craigie "lingual quinsy," in other words, an acute inflammation involving the base of the tongue as well as the tonsil. The patient was a boy, fourteen years of age, evidently very poor, who came to my clinic at the Post-Graduate Medical School, June 14, 1890. He could hardly speak intelligibly, but we were able to learn that he had had "sore throat," gradually getting worse, for four days. He felt chilly, but had had no well-marked chill. Odynphagia prevented him from eating, even the attempt to swallow fluids being very painful. Salivation was extreme. The gums were red, swollen, and sensitive, inclined to bleed, and along their dental margin there was a line of adherent secretion, almost like pseudo-membrane. The jaws could barely be closed without biting the tongue, the border of which was deeply indented and eroded. The tongue was absolutely fixed; it could not be protruded nor could its tip be raised. Its dorsum was covered by a thick "fur." The odor of the breath was almost intolerable. Buccal temperature was 101° F. The left half of the tongue was not affected. The right side was much thickened, was very hard and resistant, and on passing the finger well back to the base a point of extreme sensitiveness was found. Fluctuation could not be detected. It was difficult to explore the oro-pharynx, but both tonsils were seen to be large and inflamed, and the whole faucial region was very red; but there was no indication of abscess.

Another striking feature of the case was the extraordinary submental swelling. The tissues from the point of the chin to the hyoid were tense, brawny, very sensitive, and swollen. In the expectation that the tongue might need to be scarified, I sent the boy to the Manhattan Eye and Ear Hospital, ordered a calomel purge, the external application of ice-bags, and the use of a cold carbolized mouth-wash. The next day the symptoms were somewhat worse, and I substituted, for the cold treatment, hot flaxseed poultices and frequent irrigation of the mouth with hot water. In my visit the following afternoon, I found that the abscess had ruptured during the morning. It was impossible to estimate the quantity of pus discharged, but it was sufficient to saturate the pillow on which the patient lay. All the symptoms were almost immediately relieved. The swelling beneath the jaw had disappeared; the tongue was still sensitive and stiff, but to a much less degree. The patient could speak more distinctly, and was anxious to try to eat something. From this time he steadily improved, and on the seventh day he left the hospital.

The point of rupture of this abscess could not be exactly determined, in this respect differing from a similar case re-

ported by myself five years ago (*Medical Record*, July 25, 1885). In the latter case the opening was found and a bent probe could be made to enter the abscess cavity.

The etiology of this, as of many kindred cases, is more or less obscure. There is no history of traumatism or of special exposure. The development of the lesion was doubtless encouraged by privation and poor food.—*Med. Record*, Aug. 30, 1890.

Parker (E. F.) on Anosmia from Tobacco-Poisoning.—Tobacco-amblyopia is now a well recognized disease, and is daily becoming a more familiar example, and an alarming evidence, of the growing abuse of tobacco-smoking.

A recent case leads us to believe that the nerve of smell as well as, though less frequently than, the nerve of sight, is sometimes injured by excessive smoking. Reference has been made to many of the standard works on the subject of anosmia, and various are the causes which are said to produce it. In the order of their frequency syphilis, traumatism, catarrh, obstruction of the nares, strong fumes, and malaria are enumerated, but we are unable to find that tobacco is held responsible for the loss of smell. This fact leads us to bring to the attention of the profession what we believe to be a case of tobacco-anosmia.

In March, 1890, Mr. A. F. S. applied for treatment, and stated that about a year ago he began to suffer from dryness of the post-nasal region and a disposition to clear the throat. Then he noticed a feeling of fulness or stuffing in his nose and a slight difficulty in nasal respiration, sometimes in one nostril, and, again, in the other. Lately he had observed that he had lost the sense of smell.

There was no specific history. He was, however, an inveterate smoker, and was in the habit of blowing the smoke through his nostrils.

Examination showed pharyngitis and an atrophic rhinitis. His sight was also slightly impaired, and this led us to suppose that tobacco was the cause of the condition.

This diagnosis subsequently proved correct, as was conclusively proven by the cure of the disease by removing the cause.

The treatment consisted mainly in total abstinence from tobacco-smoking, the administration of one-thirtieth grain of strychnine three times a day, and in the application of electricity to the nasal mucous membrane by means of a pledget of wet cotton on the end of an electrode. In about a month the power of smell began to improve, and when last seen and tested he could recognize almost any moderately strong odor.

The effect of tobacco on the eye is known to be an atrophic condition of the optic nerve resulting in amblyopia; hence it is an organic disease.

Now the sense of smell, though primarily dependent on the olfactory nerve, is secondarily dependent on several conditions, the most important of which are moisture and an unobstructed nasal passage.

Hence, anosmia may be either organic or functional, and tobacco-poisoning is, in our opinion, capable of producing either, or both. The anosmia is functional, when we have an interference with the secondary conditions necessary for the sense of smell; organic, when we have the nerve sensibility destroyed by atrophic changes.

From personal experience and from actual observation and inquiry, we are convinced that smoking is especially injurious to the nasal and post-nasal fossæ, and that by it the sense of smell is apt to be impaired, and may be destroyed.—*Med. News*, Sept. 20, 1890.

Oliver (C. A.) on Analysis of the Ocular Symptoms Found in the Third Stage of General Paralysis of the Insane.—1. The oculo-motor symptoms of the third stage of general paralysis of the insane, which consist in varying though marked degrees of loss and enfeeblement of iris-response to light-stimulus, accommodative effort, and converging power, lessening of ciliary-muscle tone and action, weakening and inefficiency of extra-ocular muscular motion,—all show paretic and paralytic disturbances connected with the oculo-motor apparatus itself, of greater amount and more serious consequence than those seen in the same apparatus during the second stage of the disease.

2. The sensory changes of the third stage of general paralysis of the insane, which, though similar to those found in the second stage of the disorder, are so pronounced as to show a semi-atrophic condition of the optic-nerve head and marked reduction in the amount of both optic-nerve and retinal circulation, with consequent lowering of centric and excen-

tric vision for both form and color—all indicate a degenerate condition of the sensory nerve action.

3. The peculiar local changes seen in these cases, which consist in conditions of the choroid and retina indicative of local disturbance and irritation of these tunics, more pronounced than those seen during the second stage of the disease—all represent the results of greater wear and tear given to a more delicate and a more weakened organ.

4. Both the motor symptoms and the sensory changes of the ocular apparatus, as thus described in the advanced or third stage of general paralysis of the insane, furnish not only evidences of a local disturbance of a more pronounced type than those shown in the second stage of the disorder, but plainly show themselves as one of the many peripheral expressions of fast-approaching degeneration and dissolution of nerve-elements most probably connected with the related cortex-disintegration and death.—*Med. News*, Sept. 20, 1890.

Keppler (F.) on the Sexual Life of Women after Castration.—The author has performed castration 46 times, obtaining a cure in 39. These operations were performed for the relief of purulent or gonorrhœal salpingitis, oöphoritis, fibroid tumors of the uterus, etc. The following were his conclusions, derived from a study of the physiological consequences of these operations: 1. When the operation was performed on account of salpingitis or other inflammatory process, uterine hemorrhage never occurred subsequently. 2. The conjugata became gradually shortened, and this was the more marked the younger the individual was when operated upon. 3. The uterus became atrophied, the vagina grew shorter and narrower, its mucous membrane became paler, and the labia majora were somewhat thinned. 4. The breasts grew smaller, acquiring a strong resemblance to the male mammæ. 5. The brown pigmentation of the nipple, areola, perineum, and anus disappeared wholly, as did also pathological pigmentation existing in some of the cases; the hair also turned white. 6. The tendency to embonpoint, which is generally believed to exist after these operations, was not observed by the author. 7. No changes were observed as regards the growth of the hair or the tone of the voice. 8. The sexual desire remained, and was the more pronounced the earlier in life the operation was performed. 9. The operation offers no impediment to marriage; three of the author's cases had married and had lived happily with their husbands for years. 10. A marriage with a castrated woman is the ideal Malthusian marriage, and the only way the Malthusian idea can be carried out without endangering the health and happiness of the woman. 11. In the cases operated upon in early life for inflammatory conditions, no neuroses were seen to develop, which was not the case when women were operated upon late in life for fibroid tumors of the uterus. 12. A favorable influence upon the hemorrhage was observed after operations for myoma, yet in no case did the menopause at once set in. 13. In cases of operation for uterine fibroma, the patients, even those in full maturity, lost all sexual inclination after the operation.—*Med. Record*, Sept. 20, 1890.

Bouilly on Remote Effects of Removal of the Uterine Adnexa.—The author bases his conclusions upon a study of upward of fifty cases observed during a period of the three years from the beginning of 1887 to the end of 1889. Cases operated upon during the present year were too recent to be used in judging of the remote consequences of the operation. The following are the general conclusions which the author drew from his study of these cases:

1. The remote effects of the removal of the uterine adnexa are excellent, and beyond any question when the indication has been furnished by certain actual lesions of the ovaries and tubes. The most important of these lesions are salpingitis and suppurating oöphoritis, and in the second rank may be classed non-suppurating, painful oöphoritis and peri-ovaritis. In these two classes of affections the results of the operation are perfect, and no other therapeutic measure could well replace the radical treatment.

2. The remote effects appear less favorable when the operation has been done on account of certain forms of catarrhal or interstitial salpingitis complicated with parametritis, in which cases total extirpation is difficult of accomplishment.

3. The treatment of nervous disturbances by ovariotomy is permissible only in cases in which the organs are demonstrated to be actually diseased. The ultimate results are the better the more distinct are the lesions found.

4. The removal of actually diseased adnexa never seems to exercise any injurious effect upon the life or after-life of the woman, who, in many cases, is restored, by means of the operation, to health and a happy existence.—*Med. Rec.*, Sept. 20, 1890.

The Nuclei of Biliary Calculi.—According to Dr. Naunyn of Strasburg, biliary calculi, though they appear to have gathered round a cholesterin nucleus, do not arise primarily from masses of this substance, but from some soft matter shed by the walls of the biliary passages, which becomes impregnated with cholesterin, not so much from the bile, perhaps, as from the catarrhal secretion of the mucous membrane of the biliary passages.—*Lancet*, Sept. 13, 1890.

Stimson (L. A.) on Injury from the Use of Esmarch's Bandage.—A young man came under treatment last March for a non-suppurative tubercular affection of the right wrist, for which excision of the wrist was resorted to. The Esmarch bandage was applied in the usual manner, with the rubber tourniquet about the middle of the arm. The wound had healed without incident, but the patient was now, two months since the operation, unable to move any of the muscles of the forearm or hand. The galvanic current showed some reaction, and the speaker thought he was able to provoke contraction of some of the muscles by application of the current to the brachial plexus. The evidence was, however, not very positive. The paralysis was due either to contusion of the nerves of the arm, applied during the operation, or else to the temporary ischæmia of the muscles produced at the same time. Innervation through the three main trunks was completely lost, the reaction of degeneration was very marked, and the change seemed to be especially marked in the interossei muscles.—*N. Y. Med. Jour.*, Sept. 20, 1890.

Charrin on Experimental Myocarditis.—Inoculating rabbits with pure cultivations of the bacillus pyocyaneus, he sometimes found marked hypertrophy of the left ventricle, at other times dilatation, occasionally amyloid degeneration of the heart, and, in one case, fatty degeneration. The hypertrophy was found in an animal which was insufficiently vaccinated and afterwards inoculated several times with virus gradually increasing in strength. The wall of the left ventricle was found very much thickened, and the microscopic changes corresponded to those seen in the heart associated with granular kidneys, and, in fact, the animal had a typical granular kidney. When the heart was found dilated, there was present marked congestion of the lungs, liver, and kidneys; and microscopic examination of the myocardium showed increase of the fibrous tissue, cell infiltration, and the presence of numerous fine blood-vessels. The experiments showed, then, that the same cause may produce various effects on the heart; and this is to be expected, inasmuch as the amount of virus injected, the length of duration of its action, its toxic products, and the constitution and resistance of the organism vary so much in the individual cases.—*Lancet*, Sept. 13, 1890.

MISCELLANY.

Bauer (J. L.) on Cancerous Stricture of the Cardiac Orifice of the Stomach; Curetting; Recovery.—A locomotive engineer, aged fifty-eight, vomited blood three times during 1876. This continued until the spring of 1887, when he had hemorrhage lasting three weeks. From that time until the day of operation, May 23, 1890, his condition has gradually grown worse, his weight having decreased from 170 to 110 pounds. During these fourteen years he experienced little or no pain. Eating was always attended with hiccough and regurgitation of whatever was eaten, except oat-meal and milk, which constituted his only diet since that time.

May 23d.—Patient chloroformed. The line of incision over the stomach—in the median line—was thoroughly washed and rendered aseptic by cleansing with 1 to 1,000 bichloride solution. An incision four inches long was made down to the peritoneum; the latter raised with forceps and incised to the same length. The stomach was secured by means of a vulsellum, and an incision three inches in length made. Before doing so, however, aseptic sponges were placed around the incision, so that blood or gastric contents could not escape into the abdomen. A finger was introduced into the opening and a thorough examination made of the stomach. The pylorus was found healthy. In, around, and radiating from the cardia, a mass of soft material with indurated base was made out, with the finger as a guide. Volk-

mann's sharp spoon was introduced, and as much as was deemed safe was scraped away. The spoon was carried one inch into the œsophagus. The stomach was thoroughly irrigated ; blood-clots and cancerous particles removed, and the incision and vulsellum punctures closed by Lembert sutures. Great difficulty was experienced in uniting the abnormal wound—skin and periosteum—owing to the peculiar conformation of the body. After some little exertion this difficulty was overcome. Except sloughing of the skin between the sutures, nothing marred his recovery, being afebrile throughout.

It is surprising that so little hemorrhage followed the use of the curette. Should it have occurred, the use of ice-water would have probably controlled it, as advised by Bernays. Considering the weak, debilitated condition of the patient, the result of the operation was certainly a good one. The patient vomited once or twice after the operation. This was controlled by belladonna. No effort was made to have him swallow solid food ; he was averse to attempting any thing of the kind. For this reason, I am unable to say whether in this respect the operation was a success.—*Kansas City Med. Index*, Aug., 1890.

Kerr (N.). Should Hypnotism Have a Recognized Place in Therapeutics ?—I have recently read how medical men have expressed their surprises at the infliction of violence aad the performance of operations without pain at hypnotic *séances*. I cannot help fancying that these professional colleagues have been just awakening from a sleep as profound as that of the eleven thousand virgins of Cologne. Thirty years ago, a fledgeling in medicine, I witnessed even more mysterious phenomena during hypnosis, and more than one hundred years ago Mesmer did as wonderful things. I believe that in medicine, at some period in our professional career, we have to get through mesmerism or hypnotism like measles. In medical infancy I had both badly, and having had no troublesome sequelæ, I have no desire for a second attack of either. I accept practically all the alleged hypnotic phenomena as facts, but in hypnosis after close watching I saw only a disordered cerebral state, an abnormal psychical condition with exaltation of receptivity and energy. Is hypnotism a desirable and justifiable remedy ? Several considerations must be taken into account in answering this question. 1. Only a limited number of persons are susceptible. 2. The after-effect was a disturbance of mental balance, a dissipation of nerve energy, and nerve exhaustion. Frequent repetition is apt to cause deterioration of brain, and nerve function, intellectual decadence, and moral perversion. 3. Hypnosis is a departure from health, a diseased state. 4. Hypnosis is a true neurosis, embracing the lethargic, cataleptic, and somnambulistic states. Thus, if a disease were cured by hypnotism this would be only by substituting another disease. 5. Though suffering was sometimes temporarily assuaged by hypnotic suggestion, the underlying disease was not necessarily cured. Anyone could obtain relief from pain by becoming drunk, but this respite was dearly bought, as drunkenness usually aggravated the diseased condition. By hypnotic anæsthesia, though evanescent oblivion might be secured, the lethal power of the morbid disorder, of which the pain was a merciful, if unwelcome, messenger, was in most cases increased. The few cases I have seen apparently benefited would probably have yielded to ordinary treatment, but the patients resisted or were passive to that, while they looked forward to, believed in, and gave themselves up to, the mesmerizer. Such cases would show a proportion of successes to the "faith cure," the "mind cure," or any other "cure." The greatest success of hypnotism was claimed in nervous diseases, which, however, were the very ailments I have seen in the long run intensified and confirmed thereby. In inebriety or marcomania no medical expert of repute has found hypnotism of value. I found its pretensions fallacious, its apparent benefit less frequent than that of sound scientific therapeutics, and at times only fostering the true inebriate diathesis. I therefore advise against the mesmeric treatment of this protean malady. But I employ, as does every intelligent physician, non-hypnotic healthy suggestion. To a trusting and receptive patient desirous to be cured of any ailment, the directions and prescriptions of a medical adviser with decided opinions were true suggestions of a safe, straightforward, reliable, and scientific character, an intellectual interchange of thought with a conscious and thinking being, not, as in hypnosis, a mechanical

impression on an unconscious, soulless mass. 6. The dangers of hypnotism, too, are very great. Each *séance* might bring the hypnotee more under the control of the hypnotist, ending often in the complete submission of the former to the will of the latter.

A jelly-fish slavery, without mental or moral backbone, is infinitely worse than days of pain and nights of agony. I have known the favorite and apparently most benefited patient of a high-minded medical hypnotist precipitated by the consequent nerve disorder into an asylum. There are many wrecked lives through mesmerism. 7. An elective and subtle affectivity, ending in disaster, might develop between operator and operated upon. 8. In the lethargic and cataleptic state criminal assaults have been committed by medical men, who have been convicted and punished. In the somnambulistic state the subject has been compelled by the operator's behest to commit crime. So serious were these evils that French surgeons have been prohibited from practising hypnotism in the army and navy. 9. It is not desirable that the control of any one's thoughts and actions should be in the keeping of a fallible fellow-mortal. It has been asserted that no one can be hypnotized unless he like. This is partly true, but persistence by a stronger will may break down the resistance of a weaker. Again, it is urged that, as with chloroform, abuse is no bar to the use of a dangerous remedy. This is not a true comparison. Chloroform has only a limited material influence, but a hypnotizer has versatile powers of cunning and ingenuity in the obtaining and modifying of the hypnotic process as affecting brain function. The restoration of the capacity to shake off and resist power already exercised by a hypnotist, is arduous and difficult. Not one in a thousand has patience to persevere long enough to regain freedom. In view of all these possible dangers, I cannot understand why medical men in family practice should have been incited to hypnotize patients of both sexes and all ages, in the daily round of domiciliary visiting. Surely the risks of groundless accusations by the hysteric females are plentiful enough without so ominous an addition. I cannot too strongly deprecate public mesmerism, medical, philanthropic, or commercial, as I consider it degrading and disgusting, particularly the medical patronage and endorsement thereof; and I sincerely hope that Britain too may soon follow the example of Holland and Switzerland and prohibit such entertainments. If hypnotism were still held lawful, it ought not, except in an emergency, to be practised except by a medical practitioner in the presence of another with a third adult present, and a record kept of the object and results of each sitting, as well as of the after-history of the case. But I would infinitely rather prefer that the medical profession should set its face against the practice as a hazardous and unreliable remedy, never free from the risk of perilous sequelæ, liable to the gravest abuses, operative with only a limited number of patients, the tendency of which is apt to be inimical to the best interests of physician and patient, to produce cerebral conditions conducive to mental unsoundness, and to transmit to posterity permanent morbid mental susceptibilities with an ill-balanced and unstable brain, more especially in these days of nerve riot, exhaustion, and unrest, when o'erwearied nature yearns with an unutterable yearning for even the briefest spell of oblivion and repose.—*Med. Press*, Sept. 10, 1890.

Cobes on Artificial Hypodermic Respiration.—All living things have a surface of absorption and elimination, by which oxygen finds entry into the body's substance, and the carbonic acid there is set free. In the higher animals the absorption and elimination respectively of these gases are carried on by means of a special apparatus, the lung, where the blood takes up its vital oxygen and rids itself of its burden of carbonic acid. But this same process is repeated, in the interior of the tissues, between the blood and cells situated at the actual focus of combustion. Oxygen introduced by hypodermic injection is absorbed by the capillaries in the same way as the oxygen which passes into the pulmonary alveoli is absorbed by the surrounding capillary network. Moreover, the carbonic acid by which the blood is charged is eliminated at the point where a traumatic emphysema is produced in the same way as in the pulmonary structure. During the injections the respiratory movements were observed to lessen, and this was proved to demonstration by tracings taken of the thoracic action. The absorption of oxygen hypodermically was found to be in direct ratio to the surface and the time the

current of gas was kept going. The elimination of the carbonic acid, on the other hand, was observed to vary according to the quantity circulating in the capillary vessels immediately adjacent to the focus of provoked emphysema. It is submitted therefore that it is clearly feasible to set up in the hypodermic cellular tissues an artificial respiration in every way similar to that which takes place normally in the pulmonary alveoli. Oxygen so injected causes no irritation or subsequent local trouble, but the gas being most active when fresh, that used for this purpose should therefore have been recently prepared. It is suggested, in fine, that artificial respiration thus carried out will be found to render vital assistance in all affections or conditions in which effectual aëration of the blood is impeded through a default in the working of the pulmonary apparatus.—*Lancet*, Aug. 30, 1890.

Pick (J.) on the Insufflation of Coal-Dust in Phthisis.—The author commenced in 1889 to draw attention to the freedom of phthisis among the North Bohemian miners who are certainly favored with this immunity. He commenced his investigations by inquiring if the alimentary canal had no influence in obtaining this result, as the dust would be conveyed with the food and drink thither, where it would deposit the contained gas, and act as an antiseptic conservative, and now asks the question if it be not rational to expect that an organ long kept under the influence of an antiseptic will strongly resist the colonization or development of an infecting germ or tubercular bacillus, and more so when we find the carbon soot of the lamp distributed along the lymphatic tract and interstitial tissue of the lung commonly attacked by the microbe. How to prove the practicability of this treatment by an artificial production of pulmonary anthracosis without running the risk of an inflammatory result, was to Pick the first difficulty. To overcome this, he commenced with inhalations of soot in a nascent state by means of a spirit lamp burning rectified oil of turpentine. The flame was covered with a glass funnel, into which was arranged wood charcoal, while the patient had a tube from this to the mouth for breathing directly. By this arrangement the soot entered the mouth and lungs as in the mines where part was swallowed and taken into the alimentary canal. In another case he prescribed tablets of lamp smoke containing a centigramme.

Twenty-four hours after ten or fifteen inspirations of this apparatus the sputa was found black, and proved that the soot had entered deep into the alveoli of the lung. With this apparatus he has administered the Fuligo inhalation without the least inconvenience or annoyance to the patient for five or six weeks twice a day. *Fuligo* is a wide term if not defined. Pick understands this to be the soot from a chimney where wood is burned, but to get quit of all remaining organic remains he subjects the raw material to a kind of roasting process, which might properly be termed *fuligo depurata*, a black light powder having no effect on the tubercular process of the lung, which it does not irritate, and seemingly has no market utility beyond the theoretical presumption of a disinfectant. This was the result of his first experiment.

The next step was to have this fuligo depurata saturated with a gas taken from coal as well as wood, which he terms *fuligo empyrrheumatica*, which is also easily borne when depurated.

This fuligo treatment may not be so marked in advanced stages of tuberculosis, but at the beginning, with good hygienic surroundings, a six weeks' treatment is notable. In all his treatment he has not observed any bad effects from absorption of the fuligo or fuligo empyrr. He has also obtained good results where the bronchial sputa has been profuse by combining Peru balsam with the fuligo—20 per cent.

By means of this fuligo treatment he has obtained good results by its use in diphtheria, where he combines with it myrtolica, carbolic, eucalyptus, etc. This form is also very efficacious in foul ulcers, which it cleans in a very short time.—*Med. Press*, Sept. 3, 1890.

Flushing the Male Bladder without a Catheter.—Staff-Surgeon Dr. Rotter of Munich recommends the following process of flushing the male bladder, which offers the advantage of saving the patient the introduction of a catheter, and of making it impossible to introduce septic matter with the instrument into the bladder. An irrigator, filled with a quart of some disinfecting, and perhaps slightly astringent, liquid, at a temperature of from about 82.5° to 86° F., has a tube six feet or more in length, with a perforated and somewhat pointed end. This end is, according to

the size of the meatus, covered with more or less gauze, which has previously been saturated with the disinfecting fluid, and is now made greasy with antiseptic vaseline. For patients with a very small orifice a very thin gutta-percha drainage-tube, a few inches in length, is attached to the end of the tube. The tube is exhausted up to its end, and completely filled with the warm fluid. The patient is told, if possible, to micturate, and then to lie on his back, with his legs a little drawn up and the pelvis supported. The end of the tube is then introduced into the urethra to the length of about an inch and there held fast by the medical man, who continually presses the glans against the tube. The irrigator is then raised first one metre high and then two, and from half a minute to two minutes, or in patients with a very strong sphincter, in three or three minutes and a half, the liquid begins to flow into the bladder. The amount is easily controlled if the irrigator is made of glass, and, if not, by the vibration which is communicated to the corpora cavernosa. If it is intended to completely fill the bladder, percussion, the appearance of the bladder above the symphysis, and, in many cases, the patient's sudden desire to micturate, will give the necessary information.—*Lancet*, Aug. 30, 1890.

Terrillon on Ablation of a Portion of the Liver by the Elastic Ligature.—A woman, æt. fifty-three, came to the hospital with a very voluminous and painful tumor in the hepatic region, which she said had been growing for over four years. An exploring puncture practised at the most salient point gave issue to a teaspoonful of liquid which resembled very much that of hydatid cysts. But, as the tumor did not diminish, laparotomy was performed by opening the abdomen parallel to the right false ribs. A very large portion of the liver was drawn out, studded with numerous hydatid cysts. Some of them were emptied, but the tumor was but little lessened in volume. This being the case, ablation was decided upon, but as the tumor had no pedicle, and it was also continuous with the liver, hemorrhage was feared, and to avoid this accident M. Terrillon placed an elastic ligature around the very ill-defined base, thus constituting an artificial pedicle. The tumor was then fixed outside the abdomen, and at the end of seven days it came away, leaving a wound behind of which the bottom was constituted by the sphacelated hepatic tissue, but separated from the peritoneal cavity by adhesion. After six weeks the wound cicatrized completely, and the woman resumed her usual occupations.—*Med. Press*, Aug. 27, 1890.

The Anilides in Puerperal Fever.—An editorial in the *Journal of the Amer. Med. Assn.*, Sept. 6, 1880, calls attention to the fact that antipyrin, antifebrin, exalgine, and similar drugs are used extensively in the systemic treatment of puerperal fever, and it concludes with the following remarks:

"In the light of all the evidence, it is impossible at present to justify the exhibition of the anilides in puerperal fever. Indeed, in view of the effect upon the blood and circulatory apparatus, it is even in order to question the propriety of using these drugs in the alleged mitigation of the pain of parturition. We advisedly employ the expression, 'alleged mitigation,' since up to the present, the reports as regards the analgesic value of the anilides in labor, while contradictory, yet indicate an uncertain, and very limited power.

"The anilide treatment of puerperal fever receives its severest condemnation, when it is remembered that for years the profession has been in the possession of a highly successful plan of treatment, and that after all, the use of these dangerous artificial drugs is a work of supererogation. As systematized some years ago by Max Runge, this plan consists chiefly in the administration of maximum quantities of food and alcohol, combined with spongings with cold water.

"Within the past six months, an example of sapræmia has come under our personal observation, in which the inhalation of oxygen apparently effected an immediate and permanent reduction of pyrexia. The gas was exhibited some hours after adequate local disinfection. Certainly, this agent is harmless, and there is presented in the researches of Gottstein an eminently rational indication for its use. If certain blood poisons, like hydracetin and the anilide reduce the physiological resistance of the blood, and so favor the increase of bacteria, why may not oxygen augment the germicidal action of the blood?"

Walker (A. W. H.) on the Poisonous Effects of Exalgine.—The patient was an anæmic, neurotic woman of twenty-

nine. Exalgine was given for neuralgia and sleeplessness. On two occasions, the pain being very severe, as much as five grains of exalgine were administered. On both occasions the effect was similar, and is described by the patient in these words:

"I entirely lost all feeling for about ten minutes, I should think, but, of course, it appeared to me a much longer period; then, having recovered partial consciousness, I felt suspended in air, a gradual sinking into space, no feeling, no pain, but quite numb, as though a cut or any sensations of pain of any kind would not have been felt. My eyes appeared to be very much enlarged, no distinctive sight, but an appearance like misty vapor before the eyes. The neuralgia returned on becoming conscious about four hours after taking the medicine. It was like coming to life after a dead faint."—*Brit. Med. Jour.*, May 31, 1890.

Barthelemy on the Ætiology of Acne.—1. The presence of acne on the face should always suggest to the physician that there is something wrong with the stomach, either dyspepsia or dilatation of the organ, which must be overcome before the acne can be cured. 2. The dyspepsia prepares the soil for the growth of the seed that produces the acne, such seed always requiring a seborrhœal soil for its growth. The seborrhœa is caused by the elimination through the glands of the skin of the products of imperfect digestion. 3. The acne itself is due to the deposit upon the seborrhœal skin of germs contained in the air. 4. Acne is contagious and self-inoculable, and therefore probably parasitic. 5. If a person once has acne, it would seem that the acne germ continues constantly upon the skin, and, though it may remain latent for a time, it is apt at any moment to become active. 6. The treatment should consist in surgical procedures for the individual lesions, and of antisepsis of the skin, stomach, and intestines.—*Monatshft. f. p. Dermat.*, 1889, No. ix., p. 406; *N. Y. Med. Jour.*, June 28, 1890.

Walker (A. C.) on Laparotomy for Gunshot Wound of the Bladder.—The patient was a young man who suffered the entrance of a bullet of 38 calibre, midway between the anterior superior spine and the median line. Bloody urine. Immediate abdominal section, suture of bladder wounds of entrance and exit. Uninterrupted recovery.—*Texas Med. Jour.*, June, 1890.

BOOK NOTICE.

Some Fallacies Concerning Syphilis. By E. L. Keyes, M.D. 1890. G. S. Davis, Detroit, Mich.

Dr. Keyes' little book, on "Some Fallacies Concerning Syphilis," should be read by every general practitioner in medicine.

It contains thirteen so-called fallacies concerning syphilis and its treatment, and is written in a style both clear and pleasing.

These fallacies, although not considered as such by many physicians, are now, with perhaps one or two exceptions, generally acknowledged by those who have made syphilis, in all its forms, a special study.

The chapter on the severity of the disease as such is especially well written, and, coming from the pen of one who has had such a vast experience in the treatment of syphilis, should merit due consideration. He says: "As to the mortality of the disease (syphilis), Dr. Van Buren, my late associate, has often expressed to me the opinion that gonorrhœa indirectly is more often the cause of death than is syphilis; and when we consider the far-reaching influence of gonorrhœa, notably its effects upon the Fallopian tubes in the other sex and its indirect effect upon the tissues of those who come under its influence, and when we reflect that bladder and kidney disease often arise as a direct consequence of gonorrhœa which has resulted in stricture, one may appreciate why this conclusion is capable of being sustained upon rational grounds."

Such an expression of opinion, perhaps rather overdrawn, will come nearer the truth than many physicians will care to acknowledge to their patients.

The fallacy that there are essential differences in the quality of syphilitic poison is probably the one chapter which will not be accepted by syphilographers. The author, in accounting for the seeming difference in the quality of syphilitic poison, says: "It may be, and doubtless is, sometimes a fact that a stranger travelling in China, in South America, in Central America, or elsewhere, and getting syphilis, acquires it in a more severe form than he would have done had he been poisoned by the home product which had been bred in and upon constitutions similar in peculiarities to his own." Such a theory is weak, and will hardly be accepted by far-sighted physicians as accounting in any way for either a mild or severe attack of the disease. The author discourses at length upon the use of mercury in syphilis, and explains what he means by the so-called "tonic action of mercury" in the disease, and why he generally prefers the protoiodide to other mercurial preparations, summing up as follows: (1) The tonic treatment of syphilis is not curative by reason of the tonic doses used; and (2) the protoiodide is the best drug to employ, not because it is any more tonic or any more curative than another, but because it irritates the intestines when used in any excess, and therefore is safe in the patient's hands.

It is a general practice among many physicians to give the so-called mixed treatment early in syphilis, to wholly rely upon the use of two drugs, mercury and iodides, for the cure of the disease, and to put great faith in the Hot Springs of Arkansas.

The author very clearly and forcibly takes up these fallacies, and disposes of them in a very convincing manner.

On the whole, the book is well worth reading, and contains, in a condensed form, a good deal of valuable information and instruction. W. C. C.

THE MEDICAL ANALECTIC AND EPITOME.

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE.

EDITED BY R. W. AMIDON, M.D.

VOL. VII., No. 10. October, 1890. WHOLE No. 162.

SOME RECENT FOREIGN CONTRIBUTIONS TO MEDICINE AND SURGERY.

Gallemærts on Pyoctanine.—The author has repeated the experiments of Stilling with this drug but arrives at somewhat different conclusons. Stilling claims that it checks the growth of microbes in proportion of 1:64.000, while 1:1000 is germicidal.

The author experimented with a 1:1000 dilution of the anilide. He found that it completely arrested the growth of cultures of the *saccharomyces ellypsoideus*, *bacillus anthracis*, and *bacillus pyogenes fœtidus*. It retarded the growth of the *bacillus fluorescens fœtidus*, while it had no effect on cultures of the *micrococcus prodigiosus*, the *bacillus pyocyaneus*, and the *staphylococcus pyogenes aureus*.—*Jour. de Méd. de Chir. et de Pharmacologie*, Aug. 20, 1890.

Derignac on a Grave Form of Icterus Cured by Gastro-Intestinal Antisepsis.—A patient had intense icterus, absolute anorexia, high fever, intense diarrhœa, and enlarged liver. Alkaline treatment failed and the case went from bad to worse. Antiseptic treatment directed to the alimentary tract brought about decided and rapid improvement. The author suggests that, in grave hepatic disturbances, gastro-intestinal auto-intoxication should be looked for and if found treated.—*Le Courrier Méd.*, Sept. 13, 1890.

Valude and Vignal on the antiseptic value of aniline colors.—The results of these experimenters are quite contrary to those of Stilling and Jänicke. They find the aniline colors very weak antiseptics and much inferior to sublimate. A 1 per cent. solution of pyoctanine needs an hour to produce the effect that a $\frac{1}{10}$ per cent. solution of corrosive sublimate will produce in from five to ten minutes under the same condition. Clinical experimentation in the service of Tarnier shows that the effect of pyoctanine is very unreliable. It appears to succeed best in corneal affections, and seems to act more by its power of diffusion than by its antiseptic power. It will only act well in ocular affections when it can be locally applied in condensed form.—*Le Courrier Méd.*, Sept. 13, 1890.

Desguin (L.) on Grave Poisoning from β. Naphthol used as an Antiseptic; Recovery.—A woman of twenty-two, ten months after confinement, was subjected to an operation for ruptured perineum May 6th. On the 4th she was purged. On the 5th she took eight powders composed of subnitrate of bismuth gr. ix., β. naphthol gr. iiss. The morning of the operation she was given an enema consisting of β. naphthol gr. 1 $\frac{1}{2}$ in water $\frac{3}{3}$ x.

Twenty minutes before the anæsthetic was commenced a hypodermic injection of sulphate of atropia gr. $\frac{1}{150}$ and sulphate of morphia gr. $\frac{1}{8}$ was given.

Chloroform was started, but, the patient getting cyanosed and syncopal, it was stopped and the operation was completed without it, sensibility being benumbed but not abolished.

On drawing the urine it was seen to be of a blackish color similar to that of carbolic-acid poisoning. The vaginal mucous membrane was cyanosed and the blood almost black.

Some nausea followed the operation, and digestion was poor for some days. The urine, of normal amount, became darker,

and twelve hours after the operation was almost black. Then it gradually cleared up, but did not become normal until the twelfth day. There was a trace of albumen in it at times. A slight elevation of temperature not deserving the name of fever followed the operation, which in spite of the poisoning was a success.—*Annales et Bull. de la Soc. de Méd. d'Anvers*, June, 1890.

Vidal on the Acetate of Ammonium in Scarlet Fever.—According to the author the acetate of ammonium is well tolerated in doses of gr. xv. for each year of age of the patient. Nevertheless he has never gone beyond 3 ix. daily doses in adults. In these full doses he thinks the drug rapidly lowers high temperatures, and constitutes the best treatment for scarlet and perhaps the other eruptive fevers, and should be given as early in the disease as possible.—*Le Courrier Méd.*, Aug. 9, 1890.

Botey (R.) on the Possibility of Tracheal Injections in Man as a Means of Introducing Medicines.—After experimenting on animals the author experimented on himself. He anæsthetized his larnyx with a 10 per cent. solution of cocaine and then introduced, by means of a syringe, into the trachea 3 iiss. of distilled water. No disturbance, not even cough, was produced. Later he introduced 3 vi. of distilled water in the same way, causing neither malaise nor cough. The respirations, however, dropped from 21 to 17 and the pulse from 82 to 74. Three days later he injected 3 ix. and eight days later 3 xii. of sterilized water with no bad effect, except a slowing of the pulse and respiration for some hours.

Upon a patient affected with laryngo-tracheal syphilis, after a little experimentation, the author was enabled to inject into the trachea, past the anæsthetized larynx, a solution containing gr. iv. of the iodide of potash and gr. $\frac{1}{14}$ of the bichloride of mercury. The local affection was in this way finally cured.—*La Tribune Méd.*, Aug. 14, 1890.

Bousquet (F.) on Cocaine in Obstetrics.—The author employs and advises the injection of m. vii. of a 5-per-cent. cocaine solution into each labium majus near the fourchette from 5 to 10 minutes before the spontaneous expulsion of the head or before instrumental delivery, if that becomes necessary. He tabulates 32 cases in which this method was followed, in some of them a cocainized vaginal tampon was also used. Twenty-two were normal, ten instrumental deliveries. There was always either suppression or mitigation of the suffering of labor. In no case were disagreeable effects produced. In two cases antipyrine was employed without effect.—*Marseille-Médicale*, July, 30, 1890.

Ferreira da Silva on a Characteristic Reaction of Cocaine.—The substance suspected of containing cocaine, or the dry residue from evaporation of its solution, is treated with a few drops of fuming nitric acid of a density 1.4. This mixture is evaporated to dryness and then treated with one or two drops of a concentrated alcoholic solution of potash, and the compound, well stirred with a glass rod, gives off a peculiar and distinct odor, reminding one of peppermint.—*La France Méd.*, Aug. 29, 1890.

Martinez (E.) on a Case of Strychnine Poisoning Cured by Chloroform Hypodermically and Tartar Emetic Internally.—A drinking man of twenty-eight took about one grain and two thirds of strychnine with suicidal intent. He was seen in 15 minutes, when tetanic seizures were coming on every five minutes and even oftener. These attacks were violent enough to throw the patient out of bed.

A syringeful of chloroform was thrown under the skin, three grains of tartar emetic were given by the mouth, and the same amount given by enema. During the next half hour the patient vomited freely many times and the convulsions became less violent. Another injection of chloroform was given and the patient was out of danger. A little chloral and bromide was given later, followed by saline cathartics for six days. Complete recovery supervened.—*L'Union Méd.*, Aug. 19, 1890.

Gallemærts (E.) and Coppez on Amblyopia from Carbon Bisulphide.—A boy of eighteen, having worked eight months in a rubber factory, sought treatment for his eyes Jan. 13, 1890. A diminished acuity of hearing and vision, with frequent headaches, were early symptoms, preceded by cramps in the calves, weakness of the legs—more of the left, and some difficulty in walking.

On examination there was found slight anæsthesia of the cornea, fingers could not be counted beyond 17½ inches. The fundus of the eye was of normal appearance. The visual field was much contracted, both

for objects and colors, and there existed a central scotoma in each field for both objects and colors.

It should be stated that the patient used neither alcohol nor tobacco, nor were there any ocular troubles in his family.

He was put on a tonic course with quinine, and later a series of fourteen strychnine injections, gr. $\frac{1}{30}$ per day, the vision improving from $\frac{1}{40}$ to $\frac{1}{5}$ in the right and from $\frac{1}{30}$ to $\frac{1}{4}$ in the left. The visual field enlarged and the gait became normal. —*Jour. de Méd. de Chirurgie et de Pharma.*, etc., July 20, 1890.

Statistics Relative to the Treatment of Typhoid-Fever. — Merklen computes the mortality of typhoid-fever when treated by cold baths to be 9.92 per cent. Debove contents himself with making his patients drink from one to seven quarts of liquid a day, in this way provoking a free diuresis, which he considers as salutary as the diuretic action of cold baths. His record is a mortality of 9.2 per cent. among 154 cases.

Gérin-Roze lost 6.66 per cent. of 45 cases; of the fatal cases two died before being submitted to treatment, and one in 24 hours. The latter's plan is as follows:

He aims at intestinal antisepsis by giving a powder of equal parts of salicylate of bismuth and naphthol. If the patients will not take this he gives sulpho-carbonated water in some infusion or hyposulphite of soda by enema.

He combats the fever by gr. xv. doses of quinine hydrochlorate or, if the rectal temperature surpasses 102°, by a cool bath. He supports debilitated cases by lemonades with wine or spirit, soups, milk, and extract of cinchona.—*Gaz. Méd. de Liége*, Aug. 7, 1890.

Unna on the Treatment of Red Nose.—In a fifth of the cases the author finds red nose due to acne rosacea with vascular dilatation. Often it seems to bear some relationship to seborrhœa of the scalp, in which case the latter condition should be actively treated.

The author treats the acne rosacea with ichthyol in gr. ix. doses internally and an aqueous lotion of the same externally. At night he applies the following paste:

Zinc ointment	ʒ v.
Rice powder	ʒ i.
Sulphur	ʒ ss.

He punctures the dilated venous trunks two or three times a week and covers the little wounds thus produced with moistened lint. For light cases and as a supplementary treatment he recommends repeated washing with ichthyol soap and hot water. —*La Pratique Méd.*, Aug. 5, 1890.

Parinaud on Cervical Adenitis Consecutive to Affections of the Eye.—The author first refers to some ocular affections accompanied by a transitory enlargement of the pre-auricular ganglion, which disappears with the lesion giving rise to it. The most common of these affections are herpes of the lids, styes, furuncles of the lid and caruncle, chancre of the lids or conjunctiva, and tubercle of various tissues of or about the eye.

The author calls especial attention, however, to an eminently infectious form of conjunctivitis, which is certainly transmissible from animals to man, and the chief characteristic of which is its tendency to provoke a considerable ganglionic enlargement.

In this conjunctivitis, which is monolateral, the ocular lesion is characterized by a peculiar granular state of the conjunctiva, which is covered with reddish, semi-transparent vegetations, among which are seen lines of smaller yellow granulations resembling tubercles.

These granulations may cover, more or less completely, palpebral and ocular conjunctiva, but they are sometimes localized, particularly under the upper lid, and as they cause no pain nor inconvenience, they are often overlooked, unless a methodical examination of the eye is made.

The ganglionic enlargement which appears develops very rapidly and is accompanied by a tumefaction of the entire parotid region and even of the neck. In the midst of this swelling can be felt the enlarged and sometimes softened glands.

If abscesses form they mature slowly, with almost no pain, like tubercular abscesses, often a considerable time after the ocular affection has disappeared. Like tubercular abscesses they leave indelible scars.

This affection is not tubercular, however, as its mode of evolution and the fact that all cases recover demonstrate.—*Jour. de Méd. et de Chir. Pratiques*, Sept., 1890.

Fort on the Action of a Continuous Current and Catheterization of Strictured Œsophagus upon the Human Peumogastric Nerve.—The author's experiments were performed upon a patient having a linear contraction of the

œsophagus, about 1½ inch from the cardiac orifice of the stomach. In close proximity to this spot are the two pneumogastrics and the branches of the œsophageal plexus, and upon these the author studied the reflexes of the cardiac, the auricular, and the facial nerves. In the first experiment the author introduced a small platinum negative pole into the stricture, applied the positive pole to the left side of the abdomen, and passed a current of 11 milliampères for two minutes. There resulted a quickening of the pulse from 72 to 90. There were also two intermissions of the pulse. Some voluntary contraction of facial muscles about the nose occurred.

In the second experiment 30 milliampères caused an acceleration of the pulse from 84 to 120, which fell to 80 on interrupting the current. Involuntary contraction of some of the facial muscles about the nose occurred.

In another experiment, the sound having penetrated rather more deeply than usual into the œsophagus, the pulse had not changed much, but at the moment the operator started to withdraw the instrument, the patient complained of very acute pain in the chest with sudden radiation to both ears. The pain was so severe that the patient carried his hands to his ears and complained bitterly. This pain recurred many times during the day, and could at any time be produced by passing an instrument a little larger than usual through the stricture. The current in this experiment was 22 milliampères. These reflexes were produced by more or less direct excitation of the fibres of the pneumogastric nerve, its central origin or ganglia on the course of the nerve near its origin. From the pneumogastric centre the excitation extended to the cells of the motor facial centre and the cardiac filaments of the sympathetic. As to the pain in the ears, it is doubtful whether it came from excitation of the nerve fibres, going directly from the trunk of the pneumogastric to its auricular branch or by central excitation.—*La Pratique Méd.*, Aug. 5, 1890.

Boeckel (E.) on Chronic Tubercular Peritonitis with Discharge of Thirteen Lumbricoid Worms through an Abdominal Fistula; Laparotomy; Recovery from the Operation.—A boy of seven, entered the hospital December 10, 1888. For about a year the child had complained of abdominal pains. Vermifuge medicines gave no relief. About four weeks before admission, the abdomen began to swell and become tender, and the child had to keep his bed. Fifteen days before entrance, a red, painful swelling appeared near the umbilicus.

December 11th, this swelling was incised, disclosing a large cavity lined with pyogenic membrane and fungosities containing tubercles and giant cells. A fetid gas escaped from the wound, but no intestinal perforation was made out. The cavity was scraped, and washed out with a 10 % solution of zinc chloride and stuffed with iodoform gauze.

On December 19th, a large lumbricoid worm was found on the dressing on its removal. Free suppuration set in with a slight elevation of temperature.

A month after the operation fæcal matter for the first time escaped from the fistula. On April 11th, the fistula was suppurating more than ever and a new fistula had formed in the left mammary line on a level with the umbilicus.

Laparotomy at this time disclosed an almost general tubercular peritonitis with enlargement of the mesenteric glands. As much as possible of the tubercular exudation was removed, but irrigation was practised. The peritoneal wound was sutured wholly, the cutaneous wound partly.

Following the operation came a fall of temperature and the general condition improved; although an occasional discharge occurred, the wound made visible progress toward healing.

April 28th, the sutures were removed and healing was complete except that there remained an umbilical fistula. The patient left the hospital, the wound to be dressed every eight days.

June 15th, four lumbricoid worms escaped from the fistula, and during July eight more appeared, making thirteen in all. When reported, ten months after the onset of the sickness, the case was in the following state: The fistula persisted, but discharged little. The general health was good. Considerable weight had been gained. There was no abdominal pain. The appetite was good, the complexion normal, the stools normal and contained no lumbricoids. The absence of fæcal matter and lumbricoids in the dressings showed that the intestinal fistula had closed.—*Gaz. Méd de Strasbourg*, Aug. 1, 1890.

Guermonprez on Nephrotomy in a Patient with a Single Kidney.—A woman of forty had been treated for a localized left (?) pelvic peritonitis. She had been subject to attacks of total anuria, averaging in duration from two to three days. The last attack had lasted sixteen days. The subject was very stout, but an irregular tumor, the size of an adult head, could be made out in the left renal region. Occlusion of the left ureter by a calculus and consequent hydronephrosis was diagnosed. An exploratory operation evacuated the urine, but the patient was in such a poor condition that further interference was deemed imprudent. The patient died three days later and on autopsy it was found that there was no right-kidney, while the left was enormously dilated and its ureter was occluded by a large calculus. The uterus was double and the right (?) was the seat of a metritis which had given rise to the pelvic peritonitis of that (?) side. —*Jour. des. Sci. Méd. de Lille.*, Aug. 22, 1890.

REPORT ON ORTHOPEDIC SURGERY.

BY JOHN RIDLON, M.D.

Lane (W. A.) on Angular Curvature; Laminectomy; Recovery.—In the *Brit. Med. Jour.*, April 20, 1889, the author reported the results of laminectomy in a case of paraplegia of some standing, associated with spinal disease. The patient recovered completely from the paraplegic condition.

The case now described differs in many particulars from the one published last year. For instance, the paraplegia was developed with great rapidity; the loss of power of movement became complete within a few weeks of its first appearance; and the compression resulted, not from the rare condition of approximation of the lamina of one vertebra to the body of the other, but from the pressure exerted by a mass of tubercular material which intervened between the laminæ and dura mater. The condition of the parts found at the operation showed that any further delay in resorting to operative interference would probably have been followed by a rapidly fatal result. The case made a good recovery.—*Lancet*, July 5, 1890.

Abbe (R.) on Spinal Surgery; A Report of Eight Cases.—Three of paraplegia from fracture. One of early curetting of a vertebra for Pott's disease. Two of tumors of the vertebral canal with paraplegia. Two of intradural section of some of the posterior roots of the brachial plexus for neuralgia.

From an orthopedic standpoint the fourth case chiefly is interesting. It is as follows: Male, twenty years old. Two years before admission the man had had a pleurisy from which he recovered. Subsequently he was cured of a fistula in ano, and when he came into St. Luke's Hospital he had slight phthisical changes in the apex of the left lung, and a lumbar abscess prominent over the iliac crest. The latter was opened in September, 1889, by Dr. Curtis, and discharged profusely through three sinuses around the crest of the ilium.

In February last I found a long probe passed upward to the last dorsal vertebra, and as there was no deformity and but little pain, I considered the possibility of curetting the carious bone.

On February 5th I incised beside the twelfth dorsal, guided by the end of the probe. The transverse process of the twelfth was carious and was cleared away with a bone curette. This instrument was then worked into the body of the bone alongside the spinal dura, without injury to the latter, and a large excavation of softened bone removed to the extent of about half of one vertebral body, when on every side the curette encountered firm and apparently sound bone; the entire course of the pus-track through the soft parts was curetted and douched with sublimate solution, and finally with solution of iodoform in ether. The wounds were dressed with the usual care. In six weeks the patient was sent from the hospital with only a slight discharge, and with but one sinus.—*Med. Record*, July 26, 1890.

Smith (N.) on Fixation of the Head and Neck in Caries of the Spine and Other Cases.—The old-fashioned jury-mast, passing in an arch above the head, is a very ineffectual machine. It is often made to project far backwards, so that the patient is unable to lie comfortably, if at all, upon the back. The object of this kind of head-support is to fix the head by extension as in hanging, and it is endeavored to attain this object by means of a

support from the occiput and the lower jaw. This plan is, to say the least, uncomfortable and irksome to the patient. To be at all effectual it must be so tight that it produces considerable pressure, and interferes with the movement of the jaw. Every movement of the lower jaw will disturb the whole head, and if the disease is situated in the first two cervical vertebræ, this movement will very seriously disturb that part.

The head is grasped by a band, which encircles the cranium from the forehead to the occiput in the position of the brim of a hat which is pushed well on to the head. The front part of this band is flexible, the posterior half is firm, being made of metal covered with some soft material. To the most posterior part of this band—that is at the central point of the occiput—a metal stem a foot in length is attached, which can be easily bent by means of wrenches into the desired shape. This passes downwards, and is attached to the upper part of the dorsal support. Alterations in the exact position of this vertical bar may be readily made either before or after the lower part of it is fixed, and as a rule these alterations can be made with greater advantage while the instrument is being worn by the patient, and without removing it. In acute and very advanced cases, where very slight movements give great pain, and where we may do serious mischief unless great gentleness is observed, this mode of adjustment of the bar is too rough, and it is necessary to have rack joints for the purpose. These rack joints are to be made at the place where the vertical bar is attached to the head-piece, and where this bar approaches the dorsal support. The upper joints at the upper part of the neck permit the surgeon (1st) to move the head from side to side; (2d) to rotate the head; (3d) to move it backwards and forwards. In all these cases the neck remains in one position. The rack joints at the lower part of the neck allow us (1st) to move the head and neck together forwards and backwards; and (2d) to move them from side to side. —*Prov. Med. Jour.*, Aug. 1, 1890.

Young (J. K.) on Lateral Curvature of the Spine.—As to prognosis: In the first degree, the curvature can be readily restored by suspension, lying, or slight manual pressure.

In the second degree, the curvature cannot be entirely restored by these measures.

In the third degree, the curvature cannot be affected in the least by these measures.

The progress, unless early arrested, is usually unfavorable; but the affection may be spontaneously arrested or become stationary at any stage. In the first degree, persistent and well directed measures will permanently and surely restore the symmetry; in the second, the affection may with a degree of certainty be arrested, and, especially in primary lumbar scoliosis, be much improved or even cured; but in the third stage nothing can be accomplished toward restoring the function of the spinal column, and measures must be directed to concealment of the deformity.

The treatment should be directed to the removal of the cause, the restoration of the health and strength, and the correction of the deformity.

The equalization of the extremities, change of occupation, assumption of a proper sitting position or carriage, and the administration of remedies for the correction of constitutional vice.

To correct or restore the deformity, properly directed gymnastic exercises are the most potent agents at our command. To assure a cure, the patient must devote herself (or himself) assiduously and persistently to the task for a long period. Self-suspension with a Sayre apparatus, double bar, horizontal bar, trapeze, or rings should be frequently practised during the day, alternated with periods of recumbency. In all of these, where possible, the hand on the concave side should be uppermost. While in the prone position, a hard curled-hair pillow or bag of sand should be placed beneath the convexity, or Wolf's suspensory cradle employed. Certain forward and lateral movements upon the chest-weights should be practised, or dumb-bell exercises employed. A very useful exercise is bending sideways supported by a strap, or over a padded bar; or, better still, while sitting, the body may be inclined forward, resting the arms upon a table, and a padded belt to which a weight is attached be passed over the deformity.

It will be observed that no mention has yet been made of the various apparatus still employed for the correction and maintenance of this deformity. The plaster-of-Paris jacket, myotomy, tenotomy, and forcible restoration under anæsthesia, have, in the writer's opinion, no place in the treatment of lateral curvature.—*Med. Age*, June 25, 1890.

Mills (C. K.) on Spasmodic Torticollis.—The writer reports one case, and comments on the cause of various spasmodic deformities of the neck. The case is as follows :

M. B., aged twenty-four, in the autumn of 1887, was thrown from a wagon, lighting on her head and back. She was much stunned, but was not unconscious, and walked home. From the time of this accident she often suffered severely with pain in the occipital region, more marked on the left side ; but she had no other inconvenience from her injuries until April, 1888, when now and then her head began to be drawn downward to the left, and her face upward to the right. These attacks of spasm became more and more frequent and soon almost continuous. She had been treated with medicines and counter-irritants without any marked improvement. The spasm is brought on by walking, excitement, or by pressure in the left occipital region. She has a spot of great tenderness about one inch to the left and a little above the occipital protuberance, and pressure here will bring on the spasm or increase its violence. — *University Med. Mag.*, Feb., 1890.

Vance (R. A.) on Injuries of the Hip and Absorption of the Neck of the Femur.—In the interpretation of these cases during life a history of the patient is of the utmost importance. Absorption of the neck of the femur may follow the most diverse injuries. If there has been fracture or dislocation, the surgeon will always guard his prognosis ; it is in the slighter cases, and those where a simple contusion alone is apparent, that trouble is apt to arise ; conversely, in patients where an injury of the hip is not attended by inability to walk that lasts for weeks ; where no shortening occurs at first, but is of late development and gradual onset ; where the defect in length is shown not to be located in any other part of the limb than the region around the joint, and where other parts of the body are free from evidences of chronic rheumatic arthritis, the morbid anatomical condition is absorption of the neck of the femur.—*N. Y. Med. Jour.*, July 18, 1890.

Bauer (J. L.) on Hip-Joint Disease.—The writer is one of the few who believe that the cases which recover are those in which the synovial membrane of the joint is primarily affected. Here rest is the cardinal principle of treatment ; it not only relieves pain, but assuages the peripheral irritation from which the spastic muscles or night cries arise. In these cases traction offers no advantage whatever over less complicated and cumbersome methods. The Thomas hip-splint or plaster-of-Paris will effect as good a result as pulleys and shot. No deformity ensues.

A goodly number of cases remain in which our skill is but "passing show." Whatever we may do is fruitless, and at last, after lingering suffering and physical wasting, excision completes the picture.—*St. Louis Clinique*, June, 1890.

Ballantyne (J. W.) on Intra-Uterine Rickets.—In the case reported, the limbs are curiously contorted, and nodular swellings mark the position of the shoulder, elbow, wrist, hip, knee, and ankle joints. In the position of the coccyx is a tail-like projection. The fingers and toes are long, and are widely separated from each other. The head appears to be large in comparison with the body, the upper jaw is somewhat prominent, and the occipital region is flattened. There is on the face a peculiar senile look, quite foreign to the expression of the healthy new-born infant. The umbilical cord is seen to be attached to the abdomen, and shows no signs of having been tied. The attitude in which the fœtus lies is characteristic, and is most probably approximately that which it occupied in utero. The head is flexed upon the sternum, the arms are folded upon the chest, and the legs are flexed and curiously interlocked. The thorax is expanded at its base, and is narrow from side to side anteriorly. The swollen knee and ankle joints are very evident, as is also the projection in the neighborhood of the coccyx. A penis is present, but the scrotum is quite collapsed, and does not appear as if it contained testicles. A medium raphe stretches from the root of the penis to the anus, and the anal aperture is situated immediately in front of the coccygeal projection.

Such were the outstanding features which this specimen presented to the eye ; the following additional characteristics became evident on closer examination. There was immobility of the limbs at the various joints, and the right thigh was found on palpation to be fractured. So firmly fixed were the joints that an attempt to move the arm at the shoulder resulted in the separa-

tion of the shaft of the humerus from the head of the bone. It was also found that the vertebral column was rigidly fixed in a position of flexion. The lower end of the sternum was tilted sharply forwards, and through the skin the extremely contorted form of the scapulæ could be distinctly felt. The total length of the fœtus was 47 *ctms.* (18½ inches), and the length of the head and trunk from the vertex to the top of the coccygeal projection was 35.6 *ctms.* (14 inches). The circumference of the body at the level of the ensiform cartilage was 23 *ctms*, and at the level of the umbilicus 21.7 *ctms.*

The abdomen of the fœtus was opened, and there was found in the peritoneal cavity a small quantity of serous fluid; but there was no gluing together of the intestines or other sign of inflammation. The testicles, which had not descended into the scrotum, were found lying, one on each side, in front of the psoas muscle, a little above the plane of the pelvic brim. The liver, spleen, and kidneys had a normal appearance, and the stomach was empty and collapsed. In the thorax the lungs were found in an unexpanded condition lying posteriorly to the heart, and in the latter organ the foramen ovale was patent, as was also the ductus arteriosus. It may, therefore, be concluded that respiration was never established. Subcutaneous adipose tissue was found all over the body, but it was present in smaller amount than in a healthy full-time infant. The absence of the testicles from the scrotum served to explain the peculiar appearance of the perineal region.

A description of the bones is then given, which it is impossible to abstract, and for the reproduction of which entire we have not space.—*Edinburgh Med. Jour.*, June, 1890.

Gillette (A. J.) on Rachitis and Resulting Deformities.—In addition to the usual causes assigned for this disease, such as insufficiency of nutrition, lacking in quantity and quality, bad air, deficient light and warmth, want of cleanliness, bad hygienic conditions, indigestion, or lack of assimilation, want of exercise in older children, etc., he calls attention to a factor of very great importance, and one too frequently disregarded, namely, the continuance of nursing long after the proper period for weaning, when the child should be taking more solid food, and when too the mother's milk has often deteriorated in quality and become insufficient and unwholesome.—*Northwestern Lancet*, July 15, 1890.

Townsend (W. R.) on the Treatment of Flat-foot by Thomas' Method.—The report is based upon a study of over fifty cases of flat-foot seen at the Out-Patient Department of the Hospital for the Relief of the Ruptured and Crippled, New York, during the past two years, which were treated by this method. The histories of twenty-five of these cases which have recently been examined are given in a table appended to this paper.

In cases of a mild type the treatment gave relief, and it was prompt and permanent while the treatment was continued. In some, after treatment had been stopped a certain length of time, a relapse occurred; this, as in the former instance, was promptly relieved by the same treatment. In the more severe cases, but not in the severest, in most instances the treatment was also successful; in cases with slight spasm, that symptom soon disappeared and the foot became supple and at the same time less painful, the flattened arch became more natural, and the symptoms were more or less completely relieved. In the worst cases the treatment failed. The advantages of this form of treatment are:

1. Simplicity.
2. Success in proper cases.
3. Cheapness.—*Jour. Am. Med. Assoc.*, Aug. 9, 1890.

Morton (T. G.) on the Pathology and Treatment of Club-foot, Especially Varus and Equino-varus.—The writer divides these deformities in two classes, as follows:

1. The simple, or uncomplicated.
2. The complicated.

1. *Simple or uncomplicated.* In this division are those cases which, if seen at or shortly after birth, can be rectified by traction, stretching, massage, electricity, and the use of proper apparatus. In such cases there is little or no change in the shape, or articulation, of the bones of the tarsus. Flexion and extension are nearly normal, the deformity being entirely in the soft parts. Such cases are so amenable to treatment that by the time the child is able to stand, or ready to walk, the sole of the foot can usually without much, if any, effort be placed upon the ground. Although the varus in these cases can always be cor-

rected without operation, there may develop during this period (or it may have existed from birth) a disposition to equinus, so that when the child is ready to walk, if equinus exists, even to a moderate extent, the tendo-Achillis should be divided, but tenotomy should never be performed until this time. Afterward the child should be encouraged to walk, so as to keep the foot well stretched, the ankle motion free, and the ends of the divided tendon well apart. An appropriate, light apparatus, should be worn from early age, and subsequently until all tendency to contraction has disappeared. With careful watching, the result in such cases will usually be a perfect cure.

2. *Complicated.* But again we meet at birth with a form of talipes which I have designated as the "complicated" variety. Cases of this kind will not yield to treatment suited to the mild or uncomplicated form. In such cases we likewise find varus and equinus, and although we can usually overcome the varus, the equinus cannot be corrected; the foot cannot be brought into the right-angle position with the leg. In such it will be found that the normal depression on the dorsum of the foot, just in front of the fibula, is filled with a prominent irregular mass of bone which can be readily outlined, especially if the foot be placed in a position of extreme varus. This projecting bone, arch-shaped, is the astragalus which has been forced out of its normal position of articulation with the os calcis. The tibia and fibula are found more posterior than in the normal condition; in other words, from long tendo-Achillis contraction, exerted probably from an early period of fœtal life, a partial or complete backward dislocation of the tibia and fibula has occurred, while the astragalus, at the same time, is pushed forward from its natural position and is rotated. In this manner the equinus is produced and maintained.

In the deformity just described the leg-bones rest in part or absolutely upon the calcis, forming a new joint, while the displaced astragalus represents a sort of a wedge in front of the ankle, which interferes with the joint motion, and effectually prevents flexion of the foot to a right angle.

In these cases the astragalus will be found to be the source of obstruction, and it is principally to this pathological condition that our attention must be directed.

It is beyond question, I am quite confident, that a large proportion of the unsuccessful results from operations in talipes, and the subsequent occurrence of the inveterate or severe forms of foot-deformity, are due to this condition not having been recognized or thoroughly appreciated. I am also inclined to believe that tarsotomy, tarsectomy, and the "open incision," so-called, will, if this view be correct, rarely, if ever, be required in the congenital form of equino-varus which I have described. I have on a number of occasions in times past operated on such by tarsectomy and open incision, and although improvement has followed, yet the operation has failed to overcome completely the equinus; and subsequently I have been compelled to remove the astragalus in order to correct the deformity, and to bring the foot properly on the ground, and to secure proper flexion of the joint. In all the cases of congenital equinus in which I have excised the astragalus, the removed bone was so altered from the normal as to be unrecognizable.

Under these circumstances, it is not possible to force the astragalus between the malleoli because of its altered shape and fixed position. When the condition just described is present, nothing will relieve the deformity except the removal of the astragalus.—*Med. News*, July 12, 1890.

Bauer (L.). Orthopedic Aphorisms.—1. The term "Pott's Disease" should be dropped, being indefinite and without pathological significance.

2. The inflammatory affections of the spine begin primarily either as periostitis or osteo-myelitis and should be designated by these terms.

3. The spine is more frequently the recipient of injuries than is generally presumed by surgeons.

4. When neglected or ignored, comparatively insignificant traumata may give rise to formidable lesions of the spine.

5. Menzel's and Muench's statistical tables show that of all inflammatory diseases to which the skeleton is liable, 33 per cent. are assignable to the spine.

6. Inflammatory affections of the knee-joint show, by these tables, the same percentage.

7. These large percentages are undeniable evidence that both spine and knee-joint are more frequently exposed to

traumatism than other parts of the skeleton.

8. As to constitutional invasion; spine and knee-joint can but share in equal proportions, with other parts of the skeleton, as all parts of the skeleton are equally endowed with cancellated osseous structure.

9. We think that Galen's comparison of the spine with the keel of a ship is a very significant one.

10. As a rule, the increase of the physiological curves of the spine rests upon the loss of elasticity of the inter-vertebral discs.

11. General debility, insufficient or inappropriate nutrition, anæmia, etc., may alone suffice to engender deformities, when combined with faulty habits of position.

12. Primary chondritis of the inter-vertebral discs is a very rare affection.

13. The erect posture in such cases inevitably intensifies the physiological curves.

The recumbent position aids in straightening the spine.

14. Persistent horizontal position for months will completely obliterate the curves and make the spine as straight as a plumb line.

15. Periostitis of the spine invariably produces softening of the cartilages and consequent curvature.

16. Angular inflection of the spine is a pathognomonic symptom of anterior fracture of one or more vertebral bodies.

17. When associated with a suppurative affection of the spine, angular inflection indicates material defects in the vertebral body.

18. The most projecting spinous process represents the seat of fracture or most material defect.

19. In all osseous affections of the spine rest in a recumbent position is indispensible to repair.

20. Milk diet is the most appropriate in such cases, because it carries lime salts into the system in the most assimilable form.

21. Iodoform may not be the best germicide—but an oleaginous mixture of iodoform has been found to be the most reliable obliterator of tubercular or bone abscess.

22. Experiments have demonstrated that suspension does not act upon the seat of spinal disease, but upon the inter-vertebral discs above and below the compromised locality.

23. Where the condition of softening of the cartilages exists, the recumbent position produces a more lasting and perfect effect. The plaster-of-Paris jacket is inefficient and objectionable, because it interferes with respiration, cardiac action, and digestion.

24. A month's immobility of the spine by recumbency is more beneficial to the patient than three months' of the plaster-of-Paris jacket — (ambulant).— *St. Louis Clinique*, July, 1890.

REPORT ON OBSTETRICS AND DISEASES OF CHILDREN.

BY ELIZABETH STOW BROWN, M.D.

Baldwin (J. F.) on a Plea for the More Frequent Use of Chloroform in Obstetrics.—Four objections have been offered to the use of anæsthetics in labor:

1. The pains will cease, and labor come to a standstill.

2. Uterine contractions will be less vigorous, and the voluntary contractions of the abdominal muscles are lost.

3. The child will be affected.

4. The danger of post-partum hemorrhage is increased.

5. The inherent dangers of chloroform itself.

The writer has kept statistics of over 600 confinements. He is accustomed, during the first stage of labor, to administer morphia; during the second stage, chloroform; during the third stage, nothing. His experience warrants him in stating that the advantages of chloroform are: that it not only relieves pain, but also shortens labor, usually; prevents shock, prevents nervous and physical exhaustion, reduces the liability to rupture of cervix and perineum, does not conduce, in any material degree, to post-partum hemorrhage; does not affect the fœtus; is absolutely safe when properly administered.—*Columbus Med. Jour.*, August, 1890.

Northrup (W. P.) on a Case of General Tuberculosis in an Infant; Primary Intestinal Infection.—The patient was a female child, aged fifteen months. When two hours old it was

brought to the New York Foundling Asylum and entered upon the records of the institution as being in "good" condition. It was at once put out to wet-nurse with a healthy, strong woman, twenty-seven years old, who brought it to the asylum every month for inspection, and the records show that for nine months it continued to thrive. Seventeen days before death the child was taken from the nurse because of its miserable appearance and kept in the hospital. It had a "bad cough," was anæmic, emaciated, and had double suppurative otitis. For the remainder of its life it had a daily average temperature of 101° F., with diarrhœa. Three days before death the passages were frequent, dark, and occasionally contained blood. The temperature reached 104° F. The child died without convulsions.

On autopsy, the search for tubercles resulted in finding a few small, glassy, discrete, in the anterior portions of the lung, the lower and posterior portions of which were in a state of recent broncho-pneumonia. The liver contained small tubercles in moderate number, but was not itself enlarged. The spleen was small and contained a number of small, discrete miliary tubercles. The kidneys had each upon surface and on section from three to five distinct small miliary tubercles.

Intestines: opposite the middle of the ileum, within the mesentery, were eight to ten large lymph-nodes closely grouped together; these were cheesy and had diffluent centres. The mesentery was somewhat shortened and thickened at this point, and the intestine was sharply doubled on itself, forming a knuckle, its contiguous walls being adherent. Two sinuses, about two milimetres in diameter, having their openings in the two legs of the knuckle, passed down into the thickened and contracted mesentery in a V-shape, and terminated together in a blind ending. A bent probe could be easily passed into one sinus, dipping down into the mesentery, and made to emerge at the other sinus. In this knuckle of ileum was a single ulcerated Peyer's plaque, the ulcers having characteristic undermined edges. Here, then, in immediate juxtaposition were ulcerated plaque, old sinuses, thick and contracted cicatrix, cheesy and diffluent lymph-nodes. No ulcers were observed in any other part of the ileum, and the enlargement of the mesenteric lymph-nodes, apart from the group just described, was but moderate, and none were cheesy, none tuberculous. The tubercles of the organs other than the intestine were small, showing no tendency to degeneration, and were presumably recent.

The history is of a sickness lasting six months; wasting, anæmia, cough, severe diarrhœa with bloody passages. The probable course of the case was that tubercle bacilli found their way into the intestine, probably either in infected food or through the medium of the mouth and nose secretions in which were entangled bacilli from the air. From the ileum the bacilli found their way to the mesenteric lymph-nodes, and then set up the tuberculous process. The result was an abscess which emptied into the gut by two sinuses, and which, in contracting, brought the gut to a sharp knuckle. The neighboring lymph-nodes became tuberculous, cheesy, and diffluent, and from some source bacilli entered the blood-stream and were borne to other organs and there set up a similar process. The kidneys, liver, and spleen were moderately affected; the lungs sparingly; the brain and meninges not at all.—*American Four. of Med. Sci.*, Sept., 1890.

Stickler (J. W.) on Further Observations upon Foot-and-Mouth Disease in its Relation to Human Scarlatina as a Prophylactic.—Three years ago (1887) the writer published a paper upon the above subject. In 1886 he had visited the locality in Dover, England, where the epidemic of sore-throat in human beings occurred simultaneously with the outbreak of foot-and-mouth disease among the cattle; and had visited with Dr. M. K. Robinson, the physician in the district, the various homes where the disease had appeared. The following facts were at that time elicited:

"1. That members of eight different families, who had previously had scarlet fever, escaped the 'throat epidemic,' while all the other members contracted the disease, all alike having taken freely of milk infected with the contagium of 'foot-and-mouth disease.' The number of those who escaped was 23 +. I say plus 23, because in the case of one family we were told that the father, mother, and servants escaped, the number of servants not being stated. Allowing the number of servants to be 2, the whole number would be 25.

"2. That of 183 persons who had the 'throat epidemic,' 16 had had scarlet fever.

"3. That 4 of the 16 persons who had had scarlet fever had a mild form of the 'throat epidemic.'

"4. That 2 of the affected individuals had scarlatina when young.

"5. That none of the persons affected with the 'throat epidemic' had contracted scarlet fever from natural, accidental exposure, between the time of having the 'sore-throat' and the date of my visit (1886)."

Quite recently the author has received a long communication from Dr. Robinson, of Dover, relating to the foot-and-mouth disease, and furnishing a number of new instances of human infection. Dr. Robinson has observed that diphtheria, quite as often as scarlatina, follows in the wake of the foot-and-mouth disease in cattle. He states that "the cases of foot-and-mouth disease officially reported in England increased from 37,000 in 1882 to 461,000 in 1883, and following this enormous increase of the epizoötic disease there was a large increase in diphtheria; the number of deaths alone from this disease in England and Wales during the first quarter of 1884 being 1,270, and the death-rate from the malady higher than that recorded in any quarter of the previous fourteen years."

Dr. Stickler goes on to re-state, as "supplementary evidence" in favor of the prophylactic form of foot-and-mouth disease against scarlatina, the facts concerning three children whom he inoculated with the virus of foot-and-mouth disease. A full description of the foot-and-mouth disease is given.

In closing Dr. Stickler says:

"What I wish is simply to determine positively, and as soon as possible, whether the escape from the 'throat epidemic' of certain individuals, in the two epidemics in England, and of three children from scarlatina whom I inoculated with the virus of foot-and-mouth disease, be due to the protective influence of the one disease against the other, as appears to be the case. If we learn that we may thus prevent the development of a disease so common, ofttimes so fatal, and so frequently followed by distressing sequelæ, will we not confer a blessing on those who are susceptible to its contagium? If, on the other hand, we discover that we cannot, in the majority of instances, confer this immunity, we shall at least have made a commendable effort to realize that which a large number of clinical facts seemed to indicate as possible of accomplishment."—*Med. Rec.*, Sept. 13, 1890.

RECENT CONTRIBUTIONS ON HERNIA.

BY CHARLES A. POWERS, M.D.

Commenting on a newly proposed method for the radical cure of hernia, in the ANALECTIC, of April 25, 1889, I took occasion to say:

"Unanimity of opinion regarding the best method of performing a 'radical cure' in herniæ cannot now be obtained. But a few years have elapsed since surgeons began to boldly and ardently advocate the obliteration of the sac in reducible herniæ. There are not a sufficient number of cases on record, and sufficient time has not yet passed, to enable even the authors of the various procedures to say what are really cures and what but temporary successes."

That events have justified the foregoing expression is amply proven by a recent paper by Dr. William T. Bull (*Med. News*, July 5, 1890), which is by far the most valuable addition to hernia literature which has appeared in late years.

This article is of such value that I quote from it at length. Dr. Bull says:

"It goes without saying that in the solution of this problem (radical cure of hernia), 'accurate experience' is not the only desideratum. Observations which cover a number of years are equally important. The tendency of hernia to relapse after apparent cure was a well-established fact when mechanical treatment was the general rule of practice, and, excepting in the case of children, patients were encouraged, after the hernia ceased to appear, to continue the use of trusses as a safeguard against relapse. In illustration of this fact, Segond,[1] in his thesis on 'Radical Cure,' presents a table of thirty-nine cases, collected by Berger, in which, after apparent cure by the truss, relapse was noted at periods varying from five to sixty years.

"But in the commendable zeal to perfect some method of cure for this disabling condition, operators seem to have overlooked this tendency to relapse, and have

[1] "Cure Radicale de Hernia," p. 356. Paris, G. Masson, 1883.

been ready to propose one modification after another, with a confidence justified by only months of observation. Even since the experience of surgeons has shown that the majority of relapses occur within a year after radical operation,[1] there have been plenty of new methods, or justifications of older ones, after a brief period of waiting.

"The difficulty of tracing patients after their discharge from the hospital or private treatment has undoubtedly much to do with the incompleteness of the evidence offered in support of the different procedures. A patient who, at the end of a few months, is known to have no relapse, is counted as cured; if he then disappears the record is completed, and he stands as a 'cure,' of equal significance with one which has been examined after a much longer period of observation. The number of such cures, the continuance of which varies greatly, is a prominent factor in estimating the value of any method. This is not the accurate and continued observation which is needed.

"It will be of decided advantage, in comparing methods in the future, if we discard altogether the word 'cure,' and estimate their relative merits by a statement, first, of the total number of operations with result as to recovery, wound-complications, and healing; then, by an enumeration of the cases which have been examined at later periods, with the proportion of relapses.

"It is in accordance with these considerations that I present the results of my own work during the past seven years. In many respects the data are not so complete as they ought to be; but this shortcoming seems unavoidable in work done, as this has been, in four different hospitals, with a constantly changing staff of internes. After the injection treatment (Heaton) proved so unsatisfactory, I took up, in 1883, shortly after the publication of Leisrink's statistics,[2] the more modern methods. An examination of the methods on which Leisrink reported, satisfied me that the most essential feature of any effective procedure was that proposed by Riesel, viz.: the ligature of the sac at its highest point. This has since been generally adopted. But there was some doubt in my mind as to the relative advantage of the closure of the pillars of the external ring with sutures, proposed by Czerny, or the plan adopted by Socin, of merely leaving the canal to granulate over the sutured integuments. In the first series of cases, forty in number, I followed this plan. After exposure of the neck of the sac, by dividing the integuments and the anterior wall of the inguinal canal, the sac was isolated and ligated at its neck with catgut; the portion below was dissected out when it was small; when large, or containing the testicle, it was merely drained through the bottom of the scrotum. The wound was sutured over a drain in the inguinal canal, which was left for three or four days. This method, which may for brevity be termed the method of 'ligature and excision of the sac,' has been adhered to and favorably reported on by Socin,[3] of Bâle.

"In a second series of cases, thirty-nine in number, the method has been the same, with the addition of catgut sutures to the pillars of the external ring and the divided aponeurosis.

"The third series embraces thirty-nine cases, all operated on in 1889; in these the sac had been treated as before, but the anterior wall of the canal has been more respected and only divided when it was impossible to reach the neck by drawing down the sac. But the canal has been sutured with two layers of silk or catgut sutures, the deeper ones uniting the muscular fibres, the more superficial ones the aponeurosis and the pillars of the external ring.

"The fourth series consists of sixteen operations on children between the ages of four and fourteen. Here no one method has been adhered to, because the condition of the herniæ varied greatly.

"The total number of cases may be advantageously considered with reference to indications, mortality, complications, and wound results. As to indications of the 134 cases, 77 were reducible, 42 irreducible, and 15 strangulated. In nearly one half, then, the radical cure was added to the operation for the relief of irreducibility or strangulation. This is in accordance with the general belief, I think, that it should be done in such cases with few

[1] Anderegg: *Deutsche Zeitschrift für Chirurgie*, xxiv., 207.

[2] "Die Moderne Radical-Operation des Unterleibsbruches." Hamburgh, Leopold Foss, 1883.

[3] *Revue de Chirurgie*, April 10, 1888, 264.

exceptions. In irreducible herniæ I would except only scrotal enteroceles of long standing and voluminous contents, where the adhesions between loops of intestine are firm, and the return of the long-protruded mass is sure to be a matter of difficulty. It necessitates a prolonged operation with much bleeding and many raw surfaces, and the aperture is sure to be large and little likely to be closed long by any method of suture. In general, I believe that irreducible cases are best treated by operation; they do not bear the pressure of any truss with comfort, and are constantly liable to have fresh contents descend into the sac. It must be remembered, however, that many small irreducible ruptures, both inguinal and femoral, of a few days' duration, will undergo spontaneous reduction by rest in bed, or even while on the feet, with the pressure of a spica bandage.

"In strangulated hernia, when the gut is not returned, the radical cure must naturally be omitted. When patients are too feeble to warrant any prolongation of the operation, it is undesirable.

"There are three deaths in the entire number of 134 cases, two in the first series, and one in the second. The third and fourth lists represent 55 cases in succession with no fatal result. The first death was a man of eighty, in apparently good health, who was subjected at the same time to the radical operation for hydrocele (Volkmann's) on the opposite side. The hernia was a large, scrotal entero-epiplocele, and a portion of omentum was excised after ligating. Death resulted in twenty-four hours from the shock of slight hemorrhage into the peritoneal cavity from an atheromatous artery in the omentum, which had been cut by the ligature. The second fatal result was in a healthy patient, twenty-six years of age, whom I advised to undergo the radical operation for an irreducible epiplocele; a large bunch of omentum was removed after ligating with great care, the attention of those present being called to the advantage of using heavy silk for this purpose. Bleeding occurred after the stump was replaced in the cavity; a large incision was necessary in order to withdraw the omentum and re-ligate the vessels. The ligature had slipped. The cavity was cleansed of blood and no further oozing took place, but death resulted from septic peritonitis in twenty-four hours. The third death was from shock in a large, scrotal, strangulated case of twenty-four hours' duration.

"These fatal results are worthy of notice in so far as they serve to emphasize my conviction that old and feeble subjects should not be subjected to operation in reducible cases, and that too much attention cannot be given to management of the omentum. In cases of strangulated hernia the radical measures should be omitted if patients are not in condition to safely endure prolongation of the operation. . . .

"My practice has been to make the first dressing at the end of two or three days for the purpose of removing the tubes, and to permit the second dressings to lie in place a week, if no complication occurred.

"Of the varieties of hernia, there were 116 inguinal, 15 femoral, and 3 ventral.

"These patients were very carefully sought, but only 61 were found.

"The relapses in these cases were as follows:

"In the first series of 22 cases, 6 or 27.27 per cent., relapsed within one year.

"In the second series of 20 cases, 8, or 40 per cent., relapsed within one year.

"In the third series of 19 cases, 8, or 42 per cent., relapsed within one year.

. . . . . .

"In reflecting on the experience of these cases I am obliged to conclude that in these methods, which I have faithfully tried, there is no prospect of attaining a radical cure of any form of hernia, and that the majority of cases will be found to relapse, if followed for a sufficient time. I am convinced, however, that the attempt to cure is desirable, since the majority of patients are in better condition than before. This is certainly true of irreducible cases, and of all reducible ones which are subjected to operation, because mechanical treatment is difficult or painful. The patient who wears his truss with comfort and safety is only bettered by the operation so long as the rupture remains out of sight. The attempt to cure is furthermore desirable, since it can be made with trifling risk to life, except in feeble, old, or unhealthy patients, and with little chance of complications or accidents. My own results as to relapse being no better by the complicated method of suture of the ring alone, or of the ring and canal, than by the simpler method of excision of the sac after ligature, I shall confine myself to

that method of operation till other procedures, which have stood the test of years, make a more promising showing.

"This method has the further advantage of being applicable to all forms of herniæ.

"Of the newer operations, of which there are a multitude, I have not been unmindful in framing these conclusions. Each one has its earnest advocate; with a large number of theoretical advantages, or any brief period of observation, I doubt if any, subjected to the same continued scrutiny that my methods have been, will show better results. I am becoming confirmed in that judgment day by day in witnessing the relapsed cases that apply for trusses to the Hospital for Ruptured and Crippled. Between January and October, 1889, there were forty-five such cases, and in the past nine months there have been fully as many more. I am trying to trace the history of all these patients, about one hundred in number, in order to obtain accurate knowledge of the methods employed. It will be of interest to know that thus far, of the forty-five patients above mentioned, twenty-two have been thus investigated. Of these, eleven had been operated on by McBurney's method, the shortest period of relapse being one month, the longest eleven months. Two had been subjected to treatment by injection, according to Heaton, with relapse at two months and eighteen months. In four operated on by ligature and excision, recurrence occurred on the average at the end of one year. One, by Macewen's method, recurred in seven months. One relapse took place four years after ligation and excision of the sac with suture of the external ring. Another, five years after treatment, by purse-string suture and inversion of the sac. Two patients, in whom the sac was sutured at its neck, had relapses in four and five months respectively.

"These observations will, without doubt, be duplicated in the cases yet to be traced, and go to strengthen the conviction that all methods of radical cure will be found unsatisfactory."

Weir (R. F.) on Relapses after Operations for Radical Cure of Hernia.—In a discussion which followed the reading of a paper on Operative Treatment of Hernia, at the surgical section of the New York Academy of Medicine, Dr. Weir remarked that while surgeons had for several years endeavored to devise a certain method for curing hernia, they had not, as yet, succeeded. No method was worthy of consideration which had not been tested for at least two years.

Every method put forward showed for some months a large percentage of cures, but relapses took place later.—*Med. Record*, Aug. 16, 1890.

De Garmo (W. P.) on Relapses after Radical Hernia Operations.—In the discussion opened by Dr. Weir, (*vide supra*) Dr. De Garmo said that he was often asked why he did not operate on more herniæ. His reply was to the effect that his time was largely taken up with treating mechanically the failures of other operators. This was especially true of so-called open operations. These were the worst to manage mechanically when relapses had occurred. Instead of having a hernia coming out through the external ring, surrounded by fibrous tendons, it met no resistance at the internal ring, when the parts were known to be soft and yielding and difficult to control by truss and pad.—*Med. Record*, Aug. 16, 1890.

[A large number of relapsed cases, after operation, are applying at our hospitals and dispensaries monthly. Many of these cases have been reported as "cured" by the operators.—C. A. P.]

Lewis (D.) on a Malignant Tumor in an Umbilical Hernial Sac.—Mrs. B——, a widow, aged sixty-seven years, had suffered from umbilical hernia fifteen years, but had never worn a truss, having always reduced the protruding intestine easily and frequently, until about a year before applying for treatment.

She then began to suffer pain about the umbilicus, and had so much soreness, that for the three preceding months she had not attempted to replace the tumor. The pain increased rapidly, and radiated to the stomach and pelvic regions, and there was a marked failure in flesh and strength, frequent vomiting, constipation alternating with diarrhœa, sleeplessness, and fever.

Upon examining the supposed hernia there was found a hard, nodulated tumor of a bluish-red color, the surface of which was slightly ulcerated, in the fold of skin at the upper portion. It extended nearly an inch beyond the border of the hernial ring and seemed quite movable with the skin. An elliptical incision being made, the tumor was dissected out as far as the ring, and then carefully examined for any

intestinal contents. It evidently contained no gut, and was removed in order to facilitate examination of the parts beneath. The sac contained some omentum which was not diseased. The subperitoneal tissue was infiltrated as far as the finger could reach. It was thoroughly removed, and the wound then closed as after ovariotomy.

The patient rallied well after the operation, but died sixty hours afterward, apparently from shock, no peritonitis having developed.

The first section from the apex of the tumor proved it to be a large, round-celled, alveolar sarcoma.—*Med. Record*, Oct. 12, 1889.

Cant on a Case of Epithelioma over Umbilical Hernia.—The patient was a widow of fifty-eight years, who was admitted on July 8, 1889, with umbilical hernia of twenty years' standing, for which she has always worn a truss. On admission, the patient presented a large flaccid umbilical hernia 9 inches in diameter and pendulous, the tissues over it being extremely thin except where the ulceration was. A little to the right of its centre was a foul cancerous ulcer, 5 in. x 4½ in., oval, with an unhealthy and nodular surface, with everted indurated edges and a hard base. No enlargement of the lumbar or inguinal glands could be detected. On July 17th the new growth was completely removed by a circular incision, half an inch from its margin, through the whole thickness of the hernial sac, commencing at its lower edge. In order to expose as little of the intestines as possible, sutures of carbolized silk were put in as the incision was made. The omentum was firmly adherent to, and formed part of, the tumor. The adhesions were ligatured with catgut and divided, a very considerable portion of omentum being removed. The wound healed rapidly, leaving only a lined scar, and there was not any material rise of temperature; but the skin over the hernia sloughed a little at the side in consequence of the irritation of the gauze, though this soon healed when dressed with salicylic wool. The patient was discharged on August 26th, there being no return of the growth.

Coughing an Aid to the Reduction of Hernia.—It is an undoubted fact that coughing will produce or bring down a hernia; it is therefore somewhat surprising to hear that coughing may be useful in the reduction of hernia. M. Vandenabeele, however, has frequently found that hernia which had resisted attempts at reduction by taxis alone, yielded when the patient was directed to cough during the manual efforts to compress the sac. M. Vandenabeele's observations included both inguinal and femoral herniæ, and were not confined to either sex. He believes that during the act of coughing the hernial ring dilates somewhat, and that if well-directed taxis is employed just at the right moment most cases will yield.—*Edin. Med. News.*

Fowler (G. R.) on Indications for Radical Cure of Hernia.—As to the selection of cases in which the radical cure is to be recommended, it may be said that the operation becomes one of necessity in all young persons with hernia, in the lower walks of life where existence depends upon some form of manual labor. Among these there always exists a demand for a snug or tightly fitting retentive apparatus; this alone will in the course of time so alter the anatomical conditions as to render it next to impossible to retain the hernia in position as well as to increase the difficulties of a radical cure. Again, the expense and want of time to devote to personal needs prohibits most of this class from keeping themselves supplied with the most approved form of truss, and likewise from keeping the same in repair. Hence there is always a temptation to either do without entirely, in ignorance of the dangers of such a course, or to place reliance upon an instrument which may either be inefficient or inapplicable for other reasons. On the other hand, among the better class where ample means exists, and probably always will, to provide the best possible appliances and keep the same in an efficient condition; where the mental calibre of the patient is such as to grasp the situation and appreciate the dangers attending a careless disregard of instructions regarding the use of the truss, the operation may be regarded as one of convenience, and operative measures are to be instituted exactly as in the condition, analogous in this respect, of club-foot. The judgment in this class of cases must be largely influenced by the wishes of the patient, or his friends, if he be too young to express his own desires, the probable prognosis as regards immediate and remote success being fully explained, as well as the conditions which may be confidently looked for, and the undeniable fact being stated, in case a cure is not sought,

that a person with a hernia is always handicapped in the race of life, is the subject of a constant discomfort, and may fall a victim at any time to an accidental strangulation of the gut. I should insist, further, that if in either of these classes at any time it should transpire that the hernia cannot be retained without undue distress, or with ease and certainty, the radical cure, in view of the exceedingly favorable results obtained, is called for.—*Brooklyn Med. Jour.*, November, 1889.

REPORT ON DISEASES OF THE NOSE AND THROAT.

BY CHARLES H. KNIGHT, M.D.

Wolkowitsch on Rhinoscleroma.—The author has collected eighty-seven cases of this rare disease, eleven having been under his own observation. The subjective symptoms consist of those of an ordinary nasal catarrh, with loss of the sense of smell, but with little or no pain, unless, as sometimes happens, the lips become fissured.

Cicatricial contractions may occur, or the larynx or pharynx may be involved to a degree sufficient to cause serious dyspnœa. The disease begins very insidiously, usually in the deeper parts of the nose; whence it extends to the anterior nares, invading the tissues of the upper jaw, and possibly the lachrymal tract and the Eustachian tube. It rarely extends downward to the pharynx and larynx. It progresses steadily and symmetrically, and pursues a very chronic course, often lasting fifteen to twenty or more years.

The local changes consist of nodules or plates of cartilaginous hardness, either diffused or circumscribed, deeply situated and surrounded by a zone of brawny swelling. The nodules seldom break down, but they may undergo retrograde metamorphosis, resulting in deforming contraction of the features and of the upper respiratory passages. The only treatment is excision. A microscopical examination of the tissues was made in ten cases. The most marked histological features were a round-celled infiltration and a large amount of fibrous tissue, together with numerous larger cells, and the formation of small round spaces—"vacuoles"—due to hyaline degeneration of the large cells. The hair-follicles and sweat-glands were atrophied. Micro-organisms were always found. They stained by Gram's method, and morphologically could not be distinguished from Friedländer's pneumococcus. They occurred in large numbers, and from their constant occurrence they seemed to bear an etiological relation to the disease, although inoculation experiments were unsuccessful.—*Centralbl. für Chir.*, No. 23; *London Lancet*, July 12, 1890.

In the *Brit. Med. Jour.*, Jan. 25, 1890, Dr. W. Robertson reports a case of occlusion of the nares by membrane, which he suggests may have resulted from an exhausted rhinoscleroma. The case was successfully treated with the galvano-cautery.

Buck (A. H.) on the Renewed Employment of the Nasal Douche and Kindred Procedures.—The author has observed a recent increase in frequency of aural complications resulting from the use of the douche, from snuffing up fluids through the nasal passages, and from syringing the cavities. In a small group of cases the aggravation of the aural symptoms seemed to owe its origin to the frequent use of Dobell's solution in the form of a nasal spray. He recommends as substitutes, which in his hands have never done harm, sprays of eucalyptol, oil of wintergreen, and menthol in benzoinol, or if preferred a dilution of Listerine, one to three of water. The only *curative* measures which he recognizes are the removal of hypertrophied tissue and the local application of silver nitrate.—*Med. Rec.*, Sept. 6, 1890.

Quinlan (F. J.) on a Case of Electro-Cauterization of the Middle Turbinated Bone, Followed by Meningitis.—This patient had been subjected to a number of intranasal operations before that which was associated with her fatal illness. She was a poorly nourished girl, eighteen years old, giving the usual symptoms of hypertrophic rhinitis. Her inferior turbinated bodies had been reduced by the galvano-cautery, and an ecchondrosis and an exostosis of the septum had been removed by means of the trephine and the saw. The middle turbinated bodies were subsequently removed in part with the alligator forceps, for the purpose of relieving symptoms referable to pressure of these bodies upon the septum. No untoward symptoms followed any of these opera-

tions. Relief not being complete the stump of the right middle turbinated body was lightly touched with the galvano-cautery. Shortly after her return home the patient had an attack of vomiting, and was seized with excruciating pain in the head. Death occurred about seventy hours after the operation. The author finds the lesson of this case to be that we should always get a thorough and accurate history of our patients before exposing them to the risk of a surgical operation. This patient, for example, was in an abnormal nervous condition, to say the least, at the time of operation, which perhaps should have been recognized.

(The title of this paper seems to be unfortunate in two respects. In the first place, "slight" cauterization, such as seems to have been practised, could not have affected the turbinated *bone*. Secondly, a careful study of the history persuades one that the meningitis did not "follow" the operation, but must have been actually incipient at the moment. It would be extremely deplorable should any one misconstrue this report into an argument against the use of electric cautery. If used with discretion we have no safer or more efficient agent).—*Med. Rec.*, Sept. 13, 1890.

Owen (E.) on an Anomalous Case of Salivary Calculus.—The case was complicated by the presence of a lipoma of the cheek, so that the calculus was not discovered at the time of the operation for removing the tumor. The lipoma was removed from its bed between the buccinator and masseter muscles by an incision within the mouth. Several days after, the concretion, which proved to be phosphatic, the size and shape of a date-stone, was detected in a dilatation of Stenson's duct behind the ramus of the jaw, whence it could be pressed forward to the hinder border of the masseter. From the latter position it was extracted by an external incision.

No one who has carefully dissected the face can fail to have noticed the pad of yellow fat which is lodged between the masseter and buccinator, the little pellets of which obeyed the slightest touch of his forceps. But in the case under consideration the mass of fat far exceeded the normal amount, and when drawn out through the mouth constituted a lipoma of a very respectable size. Moreover, the swelling which had previously disfigured that cheek had so entirely disappeared that I felt justified in saying that the operation would prove entirely successful. Probably the irritation caused by the salivary calculus had brought about an over-nutrition of the fatty pad, and so determined its hypertrophy, the other cheek remaining of normal size and appearance. Certainly the removal of the calculus alone would not have restored the symmetry, and had I extracted the concretion on the first occasion I might have hesitated to proceed to the ablation of the buccal lipoma, even if I had made a correct diagnosis of the nature of that swelling. Thus, as possibly not infrequently happens, failure on the part of the surgeon either in the way of diagnosis or treatment, worked for the good of the patient. As regards the removal of the calculus from the outside of the cheek, it is not an operation which one would generally recommend lest a troublesome salivary fistula should result, but, seeing the perfect way in which the wound healed, the danger of such a contingency is probably over-rated.—*Lancet*, July 12, 1890.

Baron (B. J.) on the Symptoms and Treatment of Outgrowths from the Back of the Tongue.—The chief symptom described is a sensation of "fulness in the throat," inducing the patient to clear the throat incessantly but without effect. This varies with the general health, and is undoubtedly aggravated by acid dyspepsia, constipation, cold, damp weather, and excessive use of the voice. Sometimes there is distinct interference with swallowing, and the food may actually become lodged at the base of the tongue so as to interfere mechanically with the entrance of air into the larynx, or to excite reflex spasm. In other cases there is serious interference with vocalization. The emission of high notes, particularly, in which the epiglottis tends to become more erect, requires more effort, and the throat soon becomes fatigued. The author has met with one case in which intermittent neuralgic pain, radiating from the throat down into the upper part of the chest and over the shoulders, entirely disappeared after removal of the growths. Intense pain, hemorrhage, and acute suppuration have been observed by others. The best treatment is the application of a flat electrode at a *cherry-red heat*. There is no bleeding and but little pain. From five to seven days later the operation may be repeated, and from five to ten sit-

tings are required to clear away all the growth. Subsequently the throat is painted with a solution of zinc chloride, 10 to 15 grains to the ounce of glycerine. Astringent applications may give temporary relief, but will not cure. The method is free from danger if reasonable care be taken. The author is not in the habit of using cocaine, but, in very sensitive patients, applies a ten-per-cent. solution to lessen pain and to give the patient confidence so that he will keep his head steady.—*Bristol Med.-Chir. Jour.*, June, 1890.

Moure (E. J.) on Tonsillotomy Followed by Serious Hemorrhage.—The patient was a child seven years old, whose tonsils were hypertrophied and at the same time affected with an acute inflammation. Immediate hemorrhage was slight. During the night a severe hemorrhage occurred, which was finally controlled by means of pressure and iced drinks. Eight days later the bleeding recurred.

Holst, in the *Int. klin. Rundschau*, No. 21, 1890, reviews the etiology, prophylaxis, and treatment of hemorrhage after tonsillotomy. The carotid cannot be cut, but the ascending pharyngeal may be wounded if the tonsil be dragged too far forward. Bleeding may result from inability of the arteries to retract and close, owing to cirrhotic metamorphosis of the tonsil, or it may occur if the tonsil be excised during an attack of inflammation. He advocates removal of only two thirds of the organ, claiming that the remainder atrophies. Slight hemorrhages are treated by ice and styptics; severe, by the hot iron, or ligature of the carotid. Tracheotomy and tamponing of the pharynx may be necessary.

Quéme appears as an advocate of the galvano-cautery in children as well as adults, never having observed any accident with this agent.—*Jour. of Laryngol. and Rhinol.*, Aug., 1890.

Dr. Jonathan Wright has devised an ingenious galvano-cautery amygdalotome, using the well-known Mackenzie instrument as a foundation.—*N. Y. Med. Jour.*, Aug. 30, 1890.

Butlin (H. T.) on Carcinoma of the Larynx.—In his monograph, published in 1883, the author recommended that laryngectomy be reserved for cases of *intrinsic* cancer in which the disease is still limited to the interior of the larynx; by *intrinsic* implying, with Krishaber, those carcinomata which arise from the ventricular bands, the ventricles, the true cords, and the parts below the cords. The object of the present paper is to discover how far this recommendation is justified, 102 operations for intrinsic cancer, performed by various surgeons on 95 patients, having been collected. Of 28 thyrotomies on 27 patients, 3 were successful—that is, were free from recurrence at least three years after operation. Of 23 cases of partial laryngectomy 4 are claimed as cures. Of 51 cases of complete excision, in 6 of whom thyrotomy had previously been performed, 8 were cured. Fifteen cures out of 95 patients might be considered a good showing but for the large immediate mortality of the operation. Operations for recurrence are not promising. The condition of the patient is much more comfortable after partial than after complete excision. In the opinion of the author, Fränkel's proposal to remove carcinoma of the cords by intra-laryngeal means is very exceptionally applicable. These investigations tend to confirm the author's original conclusion that a radical operation should be performed only in intrinsic disease, not merely on account of the situation and limitation of the disease, but because intrinsic carcinoma is a comparatively mild disease. —*Brit. Med. Jour.*, Aug. 23, 1890.

Ingals (E. F.) on Hysterical Aphonia.—The chief interest of this paper relates to treatment. The author follows the usual routine, except in his use of strychnia, which he gives in large doses. The initial dose is $\frac{1}{30}$ of a grain, $\frac{1}{60}$ of a grain being added to each dose every second or third day, until the physiological effects are obtained. A remarkable tolerance of the drug is noticed in these cases, sometimes as much as $\frac{1}{3}$ of a grain being given three times a day before constitutional effects are induced. Five cases are reported. —*Jour. Am. Med. Ass'n*, July, 19, 1890.

Browne (Lennox) on Congenital Enlargement of the Thyroid.—The patient, a girl ten years old, was born with a "lump" in her neck the size of a marble. At the time of operation the tumor was as large as a fœtal head at seven months, lobulated, nodular, ulcerated in places, and in front closely adherent to the skin. The tumor was dissected out without difficulty, and included the left lobe and isthmus of the thyroid body and a portion of the left lobe.

Macroscopical appearance of tumor.—The tumor weighed 8½ ounces, was of an irregular oblong shape from before backwards; encapsuled, and adherent to the skin in front. Behind there was a piece of apparently normal thyroid gland adherent to the capsule of the tumor. On section the growth was hard and grating, but not shrinking; of a pinkish white color, and intersected in all directions by dense fibrous tissue, enclosing small cysts looking like boiled tapioca, and which contained a yellowish colloid material. In the cyst walls were several cartilaginous or calcareous flakes.

Microscopical examination of tumor.—It proved to be a fibro-cystic goitre. The fibrous element was very abundant, choking up many of the follicles, which in other instances had dilated to form the numerous cysts that the growth contained. Here and there were seen remains of colloid material like large starch grains in the midst of fibrous tissue and not contained in a follicle. There were no sarcomatous elements, and the piece of thyroid gland removed at the operation was perfectly healthy. The growth was a fibro-cystic goitre originating from the isthmus of the thyroid gland. —*Lancet*, Aug. 9, 1890.

Berry (James) on Some Points in the Pathology of Goitre, with Remarks upon the Treatment by Operation.—Three methods of operating are considered:

1. Division of the isthmus with or without removal of a portion of it.

2. An operation which has recently been introduced by Mikulicz, of Cracow, under the name of resection, and which consists in removing all the goitre except a small piece on each side of the trachea.

3. Extirpation of one half or more of the gland.

With regard to the first the following conclusions are offered:

That division of the thyroid isthmus usually relieves dyspnœa not by mechanically allowing the two halves of the goitre to separate, but by draining the gland of its colloid secretion.

That the relief afforded may be permanent, but that frequently the goitre reappears when the wound has healed and the secretion is again pent up in the gland.

That in many cases where very urgent dyspnœa is present a mere division of the [redacted] will not relieve the dyspnœa sufficiently quickly, and it is necessary to do some further operation, either tracheotomy or, better, removal of some considerable portion of the goitre.

The operation proposed by Mikulicz is performed as follows:

One lobe of the goitre is isolated in the ordinary way, as if it were about to be removed, but care is taken to leave untouched the connections on the inner side, where it is in contact with the larynx, trachea, and recurrent laryngeal nerve, and where the inferior thyroid artery enters. In this region a good-sized piece of gland—enough to carry on the functions of the organ—is left intact, all the rest of the lobe being cut away. The same proceeding is then executed, if necessary, on the other side of the neck. In this operation the dangerous region is not interfered with, consequently there is no fear of injuring the recurrent nerves. The goitre is almost completely removed, but the small portions left behind obviate any danger of the supervention of cachexia strumipriva (so-called artificial myxœdema).

The operation of removing one lobe of the gland is more easily performed, but, as a rule, one of the operations is more suitable, and it is open to the objection that hypertrophy of the remnant sometimes takes place.

Cases are cited illustrating the method of enucleating and of extirpating goitre, and the mode of dressing and the after-treatment are carefully described.—*The Birmingham Med. Review*, June, 1890.

Jessett (F. B.) on a Case of Dermoid Cyst Situated beneath the Lower Jaw.—The patient was a woman, twenty-five years of age, who had first noticed the tumor ten years prior to the time of operation. Finally, the growth extended nearly to the clavicle, and protruded into the mouth so as to push the tongue over to one side. Its removal was not difficult, although the cyst was ruptured during the operation.

This case is of peculiar interest on account of its nature. Dermoid cysts are not commonly met with in this situation, although in other parts of the body they are by no means rare.

From the position of the tumor it would appear most probable that it commenced in the sublingual tissue, and as it grew it pressed outwards, and so the swelling was first noticed outside beneath the jaw, and

although the patient only remembered feeling it for ten years, yet it is not at all improbable that it was of congenital origin, and only commenced to increase in size some years after birth.—*Med. Press*, Aug. 6, 1890.

REPORT ON DISEASES OF THE EAR AND EYE.

BY A. T. MUZZY, M.D.

Moure (E. J.) on Rendering the Stapes Movable.—Loosening the stapes as a method of treatment of the adhesive form of chronic otitis media is certainly not a new operation. Kessel counselled for a long time prior to 1880 this method of treatment in cases of ankylosis of the stapes. Urbantschitsch and Politzer think that it is dangerous, being liable to break the arms of the stapes and bits falling into the internal ear, producing dangerous inflammation that might be propagated to the brain. They strengthened these adverse opinions by experiments upon the cadaver. On the other hand Poucherson states that he has secured the best of results. I have used this movement of the stapes in two different classes of cases. The first is the chronic dry otitis media. The results here depend upon the degree of the ankylosis and the constitutional condition of the patient and the rapidity of progress of the disease, together with their hereditary antecedents. As to this affection, against which we often struggle in vain, the definitive results of the loosening are not such as we would wish. The amelioration that follows the operation may and will often be considerable—stopping of tinnitus, and better hearing. But little by little the tinnitus and the deafness return. What could be expected when the general condition which first produced the disease remains the same. It is necessary, therefore, to treat this general condition, to treat effectively the patient. And hence I consider that loosening the stapes never has and never can give absolutely stable results. The second class of cases of stiffened articulations (not ankylosis of the stapes) where this method is indicated, because it gives immediate excellent and nearly always definite results, is ankylosis consecutive to otorrhœa. In cases of this class I have practised loosening already quite frequently, with varying results, it is true, but nearly always with success. Only patients having complete soldering of the plate of the stapes with the edges of the *fenestra ovalis*, or having the middle ear filled with cicatricial tissue uniting the whole chain of osslets, or alterations in the membrane of the *fenestra rotunda*, have obtained nothing from the operation. But always, even in these last cases where the result has been *nil* it is true, it has not been followed by any aggravation of the deafness imputable to the operation.—*Rev. de laryng., d'otol., et de rhinol.*, No. 7, 1890.

Graham (D.) on Massage of the Ear.—Hommel, in 1886, suggested a method he terms *Tragus Press* as a mechanical treatment of the drum. He suffered himself from chronic catarrh of the middle ear, and by this method of rapid compression and relaxation of the tragus, and its consequent change in the air pressure on the drum, he improved his own hearing from 10 centimetres to 150, for the watch. A similar result was obtained on a boy, where, after nine months of practice with this method, hearing for the watch improved from 5 centimetres 160. Hommel advises the use of this method in chronic catarrh of the middle ear; in perforations of the drum, the malleus handle still being connected with the membrane; in thickenings and opacities of the drum, and as a prophylactic to senile deafness. In the United States this method has been relegated to the patients. And it is not likely that harm could come in the foregoing classes of cases. Still harm from this procedure has been reported. A more agreeable and efficacious method is to apply the front of the metacarpal section of the right thumb to the left ear, and *vice versa*, and fitting the thumb to the auricle to make moderately strong circular kneading in a backward, upward, and outward direction. Compression and suction are created sensible to the hand as well as the ear. The benefit of these procedures is undoubtedly due to acceleration of the circulation drawing the venous blood outwards, followed necessarily by fresh blood to the ear. Stroking in front of the ear and on the side of the neck will further aid the result sought. Passive and resistive movements of the head would also assist. And the head and face may also be *massèed*

at the same sitting. While patients may attempt these proceedings upon themselves, they are of much greater efficacy when applied by an experienced manipulator. Another use of massage about the ear is for removal of foreign bodies that lie in the cartilaginous section of the canal; the fingers are pressed firmly on the skin just in front of the meatus. From here movement is made upwards and around the meatus back to the point of starting, and then the fingers are lifted. Several repetitions of this movement urge the foreign body outwards until it drops into the concha.—*Boston Med. and Surg. Four.*, April 3, 1890.

Carhart (J. W.) on Complete Closure of Both External Auditory Canals by Bone.—Examinations of the ears of a married lady, long known, for earache, disclosed complete closure of both external auditory canals by bone covered by healthy skin. Tests by the watch gave five feet, opening the mouth did not improve the hearing. She could hear conversation behind her well. This condition had never been previously noticed. The only previous history of the ears she gave was that when she took cold she had earache. It may be that the obstructing bone may act as thin diaphragms in a telephone. A somewhat similar case is reported in the *Medical Record* for Aug. 3, 1889, by Dr. E. E. Holt, of Portland, Me.—*Daniel's Texas Med. Four.*, May, 1890.

Stewart (T. M.) on Cutaneous Closure of the External Auditory Canal; A Case and Operation.—This condition may result from otorrhœa, with swelling of the tissues and their consequent union; from polypi growing together; from eczema, injuries, or maltreatment of diseased conditions. A young man complaining of great itching of the ears for the past six weeks attempted to relieve this by scratching them with a hair-pin. Growing worse, he consulted a physician two weeks ago, who ordered syringing and afterwards use of boroglyceride, but without examination. This relieved the right ear, but the left grew worse, the patient saying he could not get far enough to reach the itching in this ear. Examination shows diffuse inflammatory condition of the right ear, almost filled with dry exfoliated epithelium. Cleansing, treatment with vaseline, and protection against the hair-pin healed the right ear in three weeks. The left ear showed a false membrane across the entire canal, with a red line that might have been mistaken for the malleus handle. A crucial incision through this membrane and the pieces removed by curved scissors revealed further deposits of cheesy material. And when this was removed the true drum was found much inflamed. But under proper treatment recovery was secured in four weeks. Few cases of simple acquired cutaneous closure of the auditory canal are recorded. Dr. A. H. Buck records one in volume i. of the "Transactions of the American Otological Society"; Dr. S. Sexton, in *Am. Four. of Otolog.*, and Dr. Burnett records other cases in his "Treatise on the Ear," but these seem more of the nature of osseous than cutaneous closure.—*Pulte Quart.*, June, 1890.

(Bishop S. S.). Imperforate Auditory Canals.—Congenital and traumatic anomalies of the external auditory canals are uncommon in this country. During a practice of fourteen years the four following cases only of complete and permanent closure of the external meatus have come under my observation. Case 1. A man had several years previously been run over by a railroad train, and had the auricle severed from the head. It was replaced by the attending surgeon, though with no hopes that the man would recover. It united, but in such a manner as to close the external canal. Operation was successful in restoring the canal nearly to its normal usefulness. Case 2. An infant was brought with a congenital deformity of the auricle and absence of the external canal. The helix had several indentations. The mother says that during the fifth month of pregnancy with this child, an older child bit her ear at about the corresponding point to the indentations of the baby's ear. At the point of the meatus there was a *cul-de-sac*, pressure in which indicated an opening in the bone beneath. Four months later tests led me to believe that the child heard with this ear. But an operation found only a shallow depression of the bone. Case 3 was an infant normal in other respects, save one ear, in which no canal existed. The parents refused operative examination and aid. Case 4. A locomotive engineer, when three years old, was run over by a wagon that detached the auricle and tore off part of the cheek. The auricle had been stitched over the meatus, and it was completely closed by dense fibrous tissue.

When about twenty-two had intense pain in this ear, with suppuration through a pin-hole perforation; this discharge has continued to the present time. He said he did not hear with this ear, but tests proved the presence of sound perception. And after operation, hearing gave perception of watch at one inch, and conversation at eleven feet.—*Jour. Am. Med. Assoc.*, Sept. 20, 1890.

(Wood C. A.). Two Cases of Gunshot Wounds of the Eyeball.—If an eye recovers from a penetrating wound, it is due to two causes: the foreign body did not enter through the ciliary region, and it has passed out from the globe. It is also true that penetrating wounds from shot cause less damage and are less dangerous to the globe than other forms. Noyes says that in gunshot wounds it is impossible to decide what has happened. Case 1. A man, aged twenty-one, was shot in the face seven years before by a shotgun loaded with small pieces of stone (shingle). Pieces of stone were removed from the mouth and face, but none from the eye. For a month had severe headaches and was totally blind of the wounded eye. After a month vision gradually returned. A scar is seen on the middle of the left lower eyelid 4 mm. from the free border. On the conjunctival surface, a little higher but corresponding to the dermal scar, is a whitish puckering of the palpebral surface. No scar of sclera or cornea corresponds to this, nor does the patient remember any wound of the eyeball. But when he closes the right eye he only sees the top and bottom of objects. Pupillary reaction and accommodation of left eye normal; tension normal. Ophthalmoscopic examination of the left fundus shows a slight projection of one *D* in height at the lower border of the papilla. Its summit is quite white, and studded with cholesterine crystals. The macular region is the seat of old choroiditis. Directly outwards, from the temporal side of the disk, is a large atrophic area. Conjecture as to causes of the trouble would seem to be that more than one small piece of stone pierced the globe outside of, yet quite close to, the ciliary body, passed through the vitreous, and penetrated the opposite sclerotic wall at more than one point. The slight projection may be an encapsulated foreign body. Case 2. An Italian, fifteen years before, had been shot in the left eye, several small shots having entered the globe. After the accident he could not see much, though more than he can now, for two years ago he was struck with the fist on the same eye. About the centre of the lower lid, 10 mm. from the free border, is a scar 3 or 4 mm. across, and which corresponds to a puckering on the globe, the depression taking in the sclera and being about the same same size as the external scar. When the right eye is covered, he directs his gaze to one side to see objects directly in front. He has not had for many years any pain, lachrymation, or tenderness of the eyes. Cornea is clear, iris but slightly affected by light, tremulous; lens translucent only, and dislocated upwards. Fundus cannot be seen. After removal of the lens examination showed a large whitish area in the infra-macular region. A portion of the border of this irregular spot was plainly marked and seemed the edge of a choroidal rupture. No gross lesion in the disk or macular regions.—*Am. Jour. Ophthal.*, July, 1890.

Snell (S.) on Artificial Ripening of Cataract and Förster's Operation.—In ten cases this method of maturing the cataract by trituration of the lens capsule through the cornea had been performed. In two the result was *nil;* but in none were there any evil results; no iritis or ocular irritation had been occasioned. The increased opacity showed itself frequently in a few days, and extraction could be generally proceeded with in a month or six weeks. The stroking should be effected with gentleness and in the central portion as much as possible. Iridectomy is made downwards, is small, and extraction is done with a shallow lower flap.—*Lancet*, June 28, 1890.

Tangeman (C. W.) on Effect of Alcohol on the Eye.—It is the free alcohol in the circulation impregnating every tissue of the body that causes the pathological changes that many organs undergo in chronic alcoholism. It is claimed that when more than one and one half ounces of alcohol are ingested during twenty-four hours, free alcohol can be found in the secretions. The common apparent effects of alcohol in excess on the eye are congestion and redness of eyelids and conjunctiva. The sight easily tires; strong convex glasses are used and aid only temporarily. Objects are seen as in a fog. And at night vision is very poor, many being unable to get about alone.

The gray fog, with flashes of light emanating from it at night, are among the most frequent of the early symptoms. Up to this stage there may be no ophthalmoscopic signs. If the toxic influences continue the field of view becomes disturbed, a central scotoma develops, leaving the periphery of the field intact. About this time the color-sense seems disturbed, red suffering first and long before white; while blue remains longest. For this reason sailors and railroad hands should pass a strict color test frequently. Ophthalmoscopic examination will now show, in the majority of cases, an absolute paleness of the temporal side of the optic disk up to complete atrophy. The outer half of the disk becomes excavated, and the microscope shows fatty degeneration of nerve tissue in the location. This change begins simultaneously in both eyes, though often progressing more rapidly in one. The direction is from the globe inwards towards the brain. There will be paralysis of accommodation only in some cases. If visual power diminishes rapidly in both eyes, all the media remaining clear, we are safe in accusing the alcohol, and if these are repeated complete blindness will result. Similar results follow tobacco, lead, mercury, silver, and in some few cases quinine. The condition of the pupil is often of great service; coma from alcohol produces myosis, though sluggishly and irregularly reacting to light. Diplopia often exists from paresis of the muscular system of the orbit.—*Cincin. Lancet-Clin.*, April 12, 1890.

Thompson (J. H.) on the Abuse of Alcohol and Tobacco a Cause of Acquired Color-Blindness. — Central color scotoma is in a measure characteristic of alcohol and tobacco poisoning. The scotoma is for color principally; it is regular in its position, being placed between the optic disk and the macula; red and green are especially affected. Formerly this spot was thought to have a definite shape of oval outline with long axis horizontal. But often the outline varies. The scotoma often includes the fovea centralis. The blindness for color may in the earlier conditions exceed the general blindness. And in this consists its danger to the travelling public. In the beginning it is impossible to detect any ophthalmoscopic changes. But in the later stages signs of nerve atrophy appear. Quite a number of cases of tobacco amblyopia have been seen in diabetics, though no relation can be said to exist between the two. Some favor the idea strongly that alcohol and tobacco must be united to produce this form of blindness. This, however, is not always the case.—*Jour. Nat. Assoc. Railway Surg.*, July, 1890.

Fielde (A. M.) on Color-Sense and Color-Blindness among the Chinese, Based on an Examination of Twelve Hundred Persons.—Six hundred men and 600 women were examined by Dr. Thomson's stick of Berlin wool-tests. In this number 20 color-blind were met, 19 men and 1 woman. Of the 19 men 13 were completely green-blind, 5 were completely red-blind, and 1 incompletely red-blind; the woman was completely green-blind. The 19 color-blind men were divided thus: 11 farmers, 2 teachers, 1 hospital assistant, 1 preacher, 1 mason, 1 boatman. There was almost a universal lack of discrimination between green and blue. The tests were not well adapted for proving what was suspected,—that many Chinese are violet-blind. — *China Med. Mission. Jour.*, June, 1890.

Grossman (K.). Note on Tests for Color-Blindness.—Holmgren's test is simple, very good, and it would not be well to be without it. But it is not infallible. Recently a young man, having acquitted himself perfectly with Holmgren's wools, failed to recognize some of my glass letters. Professor Pflüger, of Berne, found in a post-graduate course of ophthalmology to sixteen army surgeons that two of them were completely red-green-blind, as tested by his own and other tests, who nevertheless made not the slightest mistake with Holmgren's wools. The wools fail especially with the educated. In examining large numbers Holmgren wools took five minutes for each person, while the twin-colored glass mosaics disposed of ten times the number in the same time. In a school a teacher used the glass letters in the following way for detecting the color-blind. He held up a sample disk before a class when no previous examination had been made and said: "You see this letter; it is a B. Write it down on your paper. Now I hold up another letter; write down what it is." Up went four boys, who said they could not distinguish any letter at all; and these were soon found to be red-green-blind.—*Brit. Med. Jour.*, Jan. 11, 1890.

THERAPEUTICS.

Rademaker (C. J.) on Bromole: Tribromo-Phenol ($C_6H_2Br_3OH$); its Uses in Medicine and Surgery.—This substitution compound has never before (to my knowledge) been manufactured or used medicinally. Bromine was used during the late civil war of the United States very successfully in the treatment of hospital gangrene, and was introduced into general practice by the late Dr. Middleton Goldsmith. But the practice was found very severe, the patient being unable to stand it without being etherized. It has also been used as an injection in cancer, but owing to its painfulness has been discarded. In the compound "bromole" these objections are not present, as the irritant action of bromine is destroyed; but its usefulness in these diseases has not been impaired. The action of carbolic acid, as is well known, prevents the production and multiplication of bacteria, and by this means suppuration, putrefaction, fermentation, and all disagreeable odors. Its influence in promoting cicatrization of wounds is readily understood. It operates by stimulating the parts to which it is applied, contracting and hardening them while it protects them from the atmosphere. The disagreeable odor of carbolic acid has also been entirely destroyed, lessening its antiseptic properties.

Bromole is a lemon-colored powder, has a sweet styptic taste and no disagreeable odor. It is insoluble in water, but freely soluble in alcohol, ether, chloroform, glycerine, and fixed and volatile oils. It has a feeble acid reaction to litmus paper. It melts at 122° Fahrenheit, and with increased heat is completely volatilized. Its specific gravity is 1882. One hundred parts of this compound contain:

72.5 parts of bromine,
27.5 parts of phenol (C. P).

Its chemical constitution is explained by the following equation:

$$\underset{\text{Phenic acid.}}{C_6H_5OH} + \underset{\text{Bromine.}}{6 \text{ atoms Br}} = \underset{\text{Bromole.}}{C_6H_2Br_3OH} + \underset{\text{Hydrobromic acid.}}{3HBr.}$$

Bromole possesses but feeble if any poisonous properties; 0.7 gram. to 0.8 gram., equal to eleven and twelve grains troy, were given to dogs weighing from thirty-five to forty pounds without any bad effects whatever. This compound contains the two most effective antizymotics known to medicine, in which the disagreeable odor of one and the irritant properties of the other are entirely destroyed without interfering with their usefulness as therapeutic agents. If fresh meat is sprinkled with a little bromole, it may be exposed to a temperature of 90° Fahrenheit for several days before putrefaction will set in.

As a surgical dressing after amputations bromole will be found superior to any antiseptic known to the profession. My experience with it is confined to the amputations of fingers and toes, but the results obtained by me were so flattering that I am satisfied it will meet all expectations in the larger operations. The form in which I use it is as follows:

Bromole	ʒ ii.
Ol. olivæ	℥ viii. M.

Cotton-seed oil, or any other kind of fixed oil, may be substituted for the olive oil.

As a dressing for wounds, or foul and indolent ulcers, I generally use an ointment, as follows:

Bromole	ʒ i.
Ungt. simplex	℥ i. M.

Or it may be sprinkled on the ulcer in the form of powder, with equally good results.

As a local application in diphtheria this compound produces excellent results when the glycerine solution is applied to the fauces. It immediately stops the foul odor in malignant forms of diphtheria, and destroys the exudation formed on the hardened glands. If the medicine is applied frequently, the indurated glands soften rapidly and all further exudation of membrane is stopped. The same can be said of its local application in scarlet fever. I prefer this compound to nitrate of silver or any other medicine that I have used.

The formula I use is as follows:

Bromole	grs. xx.
Glycerine	℥ i. M.

SIG.—Apply with a probang.

I have also used this compound successfully in croupous and tuberculous laryngitis by means of inhalation, for which I use an ordinary croup kettle; also in capillary bronchitis following measles. I generally put about ten grains of bromole in the kettle. Internally I have used it in cholera infantum, typhoid fever, and abscess of the lung, the result of which I shall report in a

future article. The dose given for internal administration was one sixteenth to one fourth of a grain.—*Am. Pract. and News*, Sept. 27, 1890.

Van Eman (J. H.) on the Specific Treatment of Typhoid Fever.—In the early part of the fall of 1889, following up the conditions under which pathogenic germs can be cultivated and reproduced, my attention was particularly drawn to the fact that all such germs could only be cultivated in an alkaline medium, and with the converse of this truth, as well, that let a culture fluid, perfect in every other respect, be either intentionally or accidentally made even slightly acid, the germ growth was at once arrested, and not only that, but the germs already in existence soon become feeble and then cease to exist.

It struck me like a revelation, that for the long-continued popularity of the acid treatment of typhoid fever I had found a rational hypothesis. More than that, it occurred to me that I had found a plan of treatment that promised to reduce the proliferation of the typh-poison within the body to the minimum, and possibly to entirely arrest it by a therapeutic agent that would have no deleterious effect on the human organism. Other germicides, such as the mercuriates, carbolic acids, etc., will, when introduced into the body in sufficient quantities to destroy the disease germs, destroy the patient as well.

Acting on my theory, I at once began the treatment of my typhoid cases, as soon as I was reasonably certain of my diagnosis, as follows: For the first thirty-six to forty-eight hours I gave calomel in five to ten grain doses until I had very thoroughly cleansed out the alimentary canal, for the purpose of either sweeping out or destroying all typh-germs that had not migrated from the intestine. While doing this I sterilized all foods and drinks, thus preventing the ingress of new germs. This being done, I put the patient on half drachm doses of dilute muriatic acid given in syrup and water, every three hours, night and day. Now as to results. In six cases thus treated, all recovered. In all diarrhœa was promptly arrested, and never gave any further trouble; in fact, some little attention was required to keep the bowels open. In no case, after the institution of this treatment, did delirium occur. Neither sordes nor dry cracked tongue in any case. In five of the cases the duration of the disease was under twenty-one days. No complication existed, and convalescence was uninterrupted and unusually rapid. In none of the cases did the evening temperature go above 103° after treatment was well commenced. In one case only, which began with an attack of la grippe, was the course protracted, lasting nearly five weeks and having as a complication hemorrhage of the bowels, which, while rather profuse, was readily controlled by morphine and ergot per orem.—*Jour. Am. Med. Assoc.*, Sept. 27, 1890.

Woodbury (F.) on Infectious Dyspepsia and its Rational Treatment by the Antiseptic Method.—Laborious, painful, and imperfect digestion, occurring habitually, when not symptomatic of other disease, constitutes dyspepsia; and when accompanied by fermentation of the contents of the stomach, and general toxic symptoms, the result of microbian development, it may properly be called infectious dyspepsia.

The disorder is sufficiently prevalent, and gives rise to enough discomfort and actual suffering in its victims as not only to deserve our serious consideration, but also enlist our best therapeutic skill in their behalf. The excessive growth of micro-organisms during digestion, is favored by slow movements of the stomach, and by defective quantity or quality of the gastric juice. Acid dyspepsia, or sour stomach, may be due to excessive secretion of hydrochloric acid (rarely), but is generally caused by lactic, acetic, or butyric fermentation, due to the pressure of appropriate forms of bacteria in the stomach.

The object of treatment of infectious dyspepsia is to prevent the excessive development of micro-organisms during digestion of food. This is sought to be accomplished (1) by the use of articles of diet which are not in fermenting condition nor readily fermentable; (2), by adopting such hygienic and tonic measures as will invigorate the bodily powers, and especially bring the gastric juice up to its normal standard of quality and quantity, and increase the muscular power of the stomach; and (3) by local antiseptic treatment including the administration of drugs which retard fermentation, and especially by lavage, or irritation of the stomach, with weak disinfectant solution, or simply recently boiled water.—*Cincinnati Lancet-Clinic*, Oct. 11, 1890.

Upshur (J. N.) on Nitro-Glycerine in Paroxysmal, Spasmodic Indigestion.—The patient was a woman, aged fifty-four years, very much "run down" from mental and physical overwork. The peculiar feature of the case was a severe periodic spasmodic pain, occurring about every ten days. It was chiefly about the pylorus, and ran downwards to the right along the edge of the ribs. When the doctor first saw her, she had had three of these attacks at intervals of about twelve hours. The first he relieved in a few hours with morphia and atropia hypodermically; the second, with two doses, each of $\frac{1}{60}$th grain of nitro-glycerine, and the third, with one dose of $\frac{1}{60}$th grain. No eructation of gas and water followed the last attack as had always been the case before. The general treatment was a light nutritious diet, attention to bowels, and phosphate of iron, quinine, and strychnine. She had no recurrence of the pain.

Nitro-glycerine was suggested by the fact that the pain, in its acuteness, resembled the spasm of angina pectoris. The author has much confidence in it for the relief of the œdema, dysnœa, and cardiac distress of Bright's disease. He has tried it with much success for the temporary relief of aggravated sciatica. Though slower in action, its effects were more permanent than nitrite of amyl.—*Va. Med. Mo.*, Aug., 1890.

The Failure of Orexin as a Stomachic.—Having, in a previous issue,[1] presented a favorable report on this new drug, it is now time to call attention to the fact that other experimenters than Penzoldt have not employed it with so happy results. The *Journal of the American Medical Association*, Aug. 23, 1890, editorially says:

"Dr. Glückziegel has reported[2] seventeen cases in which he had used orexin, in doses smaller than those used by Penzoldt, but without obtaining any improvement of the appetite or digestion. Somewhat later Imredy reported, in the *Pharmaceutische Post*, several cases in which he had employed orexin, in the same dose as Penzoldt, not only without any resultant improvement in the appetite, but even with consequent nausea in a few cases. Lastly, Martius, in the *Deutscher Medicinische Wochenschrift*, reported that in twenty-nine cases the appetite was slightly improved in five, while no effect was produced in the balance of the cases. And in the five cases that improved, the same result was obtained by using pills of marshmallow similar in size to those of orexin. In order to exclude the influence of imagination in prompting a favorable report, Martius did not let his patients learn the result he expected to obtain with orexin. Verbally we have heard of similar failures to obtain beneficial results from the drug, by observers in this country.

"No observer, therefore, has corroborated Penzoldt's successful results, that were possibly consequent upon the patient's desire to have an appetite. While it would be very desirable to have such a remedy at our command, as orexin is claimed to be, we cannot regret that this drug has failed in realizing what was expected of it. From Penzoldt's "Lehrbuch der klinischer Arzneibehandlung," we learn that 1 gramme (15 grains) of the drug costs 20 pfennige (4 cents); like antipyrin, it has been patented, and the manufacturers sell it in this country in small bottles, containing 50 tablets of 1½ grains each, for $1.50. As this is more than seven times the value of the drug, in 50 tablets, and as it is not sold at all in bulk, we are glad to show our readers, as we have practically learned ourselves, that this expensive medicament is practically useless."

Leahy (A. W. D.) on the Value of a Saturated Solution of Epsom Salts in the Treatment of Acute Dysentery.—The remedy is administered as follows: "Take a sufficient quantity of sulphate of magnesia to saturate seven fluid ounces of water, and to this saturated solution add one ounce of diluted sulphuric acid. The dose of this is a tablespoonful every hour or two, in a wineglassful of water, until it operates. Sulphate of morphia may be combined with it, or starch enemata with laudanum may be employed." I have now treated 103 cases of acute dysentery by this method, with the greatest success. In the earlier stages of acute dysentery this saturated solution of Epsom salts acts like a charm; fever, if present, disappears; mucus and blood are wanting in the stools, which become copious, fæculent, and bilious; the tenesmus ceases; the patient's anxiety diminishes; the skin acts well, and sleep follows the administra-

[1] MEDICAL ANALECTIC AND EPITOME, July, 1890, p. 299.

[2] *Prager med. Wochenschrift*, March, 1890.

tion of the first few doses. It is especially in the acute cases that sulphate of magnesia is so valuable; the more chronic the case becomes the less apparent are the advantages of this method of treatment. So utterly opposed to the accepted method of treating acute dysentery is the use of a saturated solution of magnesia sulphate, that on several occasions, when suggesting its administration to colleagues in consultation over a severe case of acute dysentery, the suggestion has been received with looks of alarm, deprecating shrugs of the shoulders, and remarks concerning the want of orthodoxy involved in such a method of treating the disease. The results furnished by this method of treatment have in most cases been so astonishing that I feel it my duty to place on record my impressions regarding it. It has no depressing action on the system, produces neither nausea nor vomiting, and quiets and soothes the patient. It relieves hyperæmia of the intestines, and in this way possibly prevents the formation of ulcers, and places those formed in the best condition for healing.—*Lancet*, Oct. 4, 1890.

O'Connell (D.V.) on the Treatment of Cholera by Blistering over the Vagus.—A man was brought to the hospital with unmistakable cholera. The usual methods of treatment, which were adopted at first, having failed to do any good, and the vomiting being incessant, I painted the right side of the neck, along the course of the vagus, with liq. epispasticus, and found, to my great satisfaction that, in from ten to fifteen minutes, the vomiting ceased, and he could now retain whatever was given him, food or medicine. This result lasted some hours, and whenever vomiting recommenced, however slightly, I applied the blistering fluid again, putting it on each side of the neck alternately, as by this precautionary measure nothing more than redness of the skin was produced, and the discomfort of a blistered raw surface was avoided. This amount of irritation of the skin, I found, was quite sufficient to prevent vomiting, and the patient being now able to retain milk, brandy, etc., and a mucilaginous astringent mixture with tr. nuc. vomicæ, he made a rapid recovery, being out of danger in twenty-four hours.—*Brit. Med. Jour.*, Sept. 20, 1890.

Cornell (S. S.) on Two Cases of Phlebotomy in Pneumonia.—A farmer, aged twenty-three years, of sanguine temperament and excellent family history, while plowing, about five o'clock in the afternoon of May 3, 1889, was suddenly seized with a severe chill, accompanied by a sense of weakness and by vertigo. Having remained supported against a fence for half an hour, he was conveyed home by his father. About an hour after the occurrence of the rigor I visited the patient. He was lying upon his back, with his neck well extended, and breathing rapidly. The temperature, taken in the axilla, was 104° F.; the pulse was 124, strong and full. Upon inquiry, no history of recent cough, of undue exposure, or of antecedent debility could be obtained; the symptoms having occurred with an awful suddenness that rendered the young man oblivious to all wants except his need of air.

A physical exploration of the chest revealed the evidences of normal lung-tissue over all regions except an extremely small area in the right infra-scapular division, where, upon inspiration, the dry clicking of crepitant râles was distinctly audible. Percussion over this region failed to elicit the smallest degree of dulness.

Sixteen ounces of blood were withdrawn from the left median basilic vein. Immediately the respirations lessened, the pulse became soft and beat less rapidly, the systemic oppression subsided, and the skin became moist with perspiration. Five grains of sulphate of quinine, in two tablespoonfuls of milk, were directed to the given at intervals of three hours during the night.

May 4th, 9 A. M.—The patient has rested comfortably during the period that has elapsed since 6 P.M. last evening. Temperature 98.5° F.; pulse 84, of small volume and low tension. The skin is moist, the tongue moist and coated, the bowels moved once during the night, and the general feeling is one of improvement. Five grains of sulphate of quinine to be given every five hours. 9 P.M.—Temperature 99° F.; pulse 86, soft and small. A severe coughing has just resulted in the expectoration of a considerable quantity of tough, fibrinous material stained with reddish-brown streaks that impart a rusty hue. Auscultation elicits subcrepitant râles over the site yesterday occupied by the crepitant râles. A draught of milk to be given whenever desired by the patient.

May 5th, 9 A.M.—The patient has passed a comfortable night; sleep has been re-

freshing, and nourishment so eagerly sought for that liberal quantities of milk have been given every three hours. Auscultation and percussion are affirmative of complete resolution in the pulmonic area involved on the 3d inst. Temperature 98.5° F. ; pulse 80, large and soft.

The patient was dismissed with a tonic of iron and quinine to be taken after meals ; walked about on the 6th of May, and resumed work on the 17th.

A farm-hand, aged twenty-one, had been feeling unwell for a week. During this period he had experienced a weakness gradually overcoming him, accompanied by breathlessness upon slight exertion, and preventing his engagement in heavy work. On June 22, 1889, a chilliness seized him, and was followed by fever, dyspnœa, and cough. I visited him the following day.

June 23d, 4 P.M.—The patient lies upon a couch on his right side; his face is flushed a deep crimson ; respirations 24 ; temperature 103.6° F. ; pulse 110, small and compressible. He coughs frequently, each paroxysm lasting a considerable length of time, and being attended by the expectoration of frothy mucus containing an admixture of pus.

The right lung from apex to base, anteriorly and posteriorly, is involved in the exhibition of mucous, submucous and subcrepitant râles, and some loss of resonance in the percussion note. The left lung exhibits greater volume and higher pitch in the inspiratory and expiratory murmur, and a percussion note so much exaggerated in resonance as to be vesiculo-tympanitic. There is anorexia ; the tongue is covered with a white fur which extends from tip to base ; the abdomen is tympanitic and the bowels are constipated. The urine is scanty and high-colored.

Eight ounces of blood were abstracted from right median basilic vein. This procedure was followed by an immediate increase in the volume and tension of the pulse, by relief of dyspnœa, and by copious perspiration. Five grains of ammonium carbonate to be given every three hours until my next visit.

June 24th, 5 P.M.—Patient feels no discomfort except that which arises from frequent coughing and abundant expectoration. Temperature 101° F. ; pulse 98, of large volume and firm tension.

The respiratory acts are less accompanied by moist râles than yesterday, the murmurs possessing greater length, greater volume, and higher pitch. On percussion, the right side of the thorax imparts normal resonance over all portions except a small area in the infra-scapular region, where the note still manifests diminished resonance.

Five grains of potassium iodide every third hour. Copious draughts of milk, and meat, potatoes, toast and tea whenever wished for.

In two weeks the patient was doing farm work.—*Montreal Med. Jour.*, Sept., 1890.

Chittick on the Treatment of Pneumonia.—The writer advocates mustard leaves and cotton, and an oil-silk jacket, in preference to poultices which are heavy and wet. He had checked the initial chill in one case by two doses of $\frac{1}{100}$ grain each nitro-glycerine, after other measures had failed. He always used bi-carbonate of ammonium first, and alcohol next, but resorted to nitro-glycerine when these were unsatisfactory, and believed it to be superior many times.—*Am. Lancet*, June, 1890.

Keefe (D. E.) on the Influence of Anæsthetics on the Pulse.—Analyzing the author's experiments we find that of the 78 cases in which chloroform was used the pulse was decreased during the first minute in 51, increased in 20, while it remained unaffected in 7.

Of the 49 cases in which A. C. E. mixture was used, the pulse was decreased in 33, increased in 13, and remained unaffected in 3.

Of the 49 in which ether was inhaled, the pulse was decreased in 26, increased in 17, and remained uninfluenced in 6 cases. Or, if we take the 176 cases with the three anæsthetics, we have 110 in which the pulse was decreased in frequency during the first minute, 50 in which it was accelerated, and 16 in which it was unaffected.

He has many records embracing not only the first minute but the second and third also, or until anæsthesia was complete. He finds it to be almost universal that in the second minute and later the pulse is decreased in force and frequency—in fact, as soon as the patient is to any extent affected by the anæsthetic. — *Provincial Med. Jour.*, Oct. 1, 1890.

Tyson (J.) on the Management of Obstinate Dropsies.—In the treatment of these cases, mainly instances of incurable kidney disease, the author has met success beyond his expectations by a diet of milk,

preferably skimmed. All had been treated with the usual diuretics and purgatives to no purpose. The author found, of diuretics, that spartein acts the best.—*Med. News*, June 21, 1890.

Doux (G.) on the Elimination of Potassium Iodide. — The author has several times during the past year had occasion to determine the amount of potassium iodide in the urine of a patient ordered to take eight grammes of the salt daily. The analyses showed the eliminated quantity to be so large and constant that M. Doux considered that further investigation of the subject would be of interest, on account of the wide limits assigned to the size of dose in treatment with this remedy. He therefore conducted a series of experiments upon himself, taking two 3-gramme doses of the iodide daily for twenty consecutive days, and determining the amount of iodide and urea present in the total quantity of urine passed every twenty-four hours. The salt could be detected in the urine thirteen minutes after ingestion of the first dose, and the daily elimination after the second day remained a nearly constant quantity, being about 90 per cent. of the dose taken, whilst no traces could be detected seventy-five hours after the last dose. At the same time, the normal amount of urea present in the urine was diminished by about one fifth. The experiments were repeated on two occasions, at two months' intervals, with the same results, but it was observed that the quantity of iodide eliminated did not exceed 60 per cent., if a little absinthe had been taken on the previous day. M. Doux further states that he was prevented from extending his field of research by the attacks of coryza, epiphora, and maxillary pains that accompanied the daily ingestion of doses varying from one to five grammes of iodide, whereas no ill effects were observed to follow a dose of six grammes, which might have been expected to increase the severity of the symptoms.—*Brit. Med. Jour.*, Sept. 27, 1890.

Reichert (E. T.) on Drugs Believed to Conserve Tissues.—The drugs referred to are alcohol, caffeine, cocaine, tobacco, opium, and hemp.

From the author's studies it seems clear that the virtues of this remarkable class of substances are due to three chief actions, one or more of which may be characteristic of each member: the production of mental exhilaration, the excitation of the energy-yielding processes, and the ability to furnish energy through their own decomposition. They in common possess the power of causing mental excitement, but which differs greatly in degree, and appreciably in its nature, some of them affecting chiefly the imagination, and others the reasoning faculties. While the condition of the mind is favorable for the manifestation of the peculiar phenomena evinced, and is doubtless the essential factor in the actions of opium and tobacco, it is evidently but secondary with the preparations of alcohol, and with the cocaine- and caffeine-bearing substances. Thus the preparations of alcohol also tend to diminish the destruction of the tissues by supplying through their own disintegration the deficit of energy thus resulting, and may enable an enormous increase in the powers of endurance and of the ability for work, even where tissue change is at its normal standard, by supplying from their own potentially laden molecules the excess of energy demanded. On the other hand, those agents which depend upon cocaine or caffeine for their activity, while of themselves incapable of yielding energy, so powerfully excite the energy-yielding processes that the tissues are consumed at a correspondingly quickened pace, and the store of energy proportionately dissipated. Figuratively speaking, alcohol is fuel added to the fire, and to the extent of the energy which it can yield will save the fuel or add that much energy; but cocaine or caffeine act as a forced draft, supplying no energy in themselves, simply causing the fire to rage more fiercely.—*University Med. Mag.*, Oct., 1890.

Reed (B.) on the Tepid Bath as a Sedative in Young Children. —The cases cited show that baths may be made especially useful in some of the acute diseases of children, and that tepid baths, under proper precautions, may exert a very marked sedative influence. Every practitioner knows the dangers of opiates when pushed unduly in the case of young children, and especially the risks involved in intrusting such medicines to inexperienced and excitable nurses. The tepid bath is a most efficient sedative, particularly when there is cerebral irritation, and it is, probably at least, as sure as any of our ordinary anodyne remedies in the control of abdominal pain in young chil-

dren, after the bowels have been thoroughly opened, so as to remove offending causes, such as partly digested food.

In treating babies with indigestion, or any of the ordinary forms of intestinal disease, the author always provides for thoroughly emptying the alimentary canal, at least once in two or three days, by giving a light dose of spiced syrup of rhubarb, or other suitable mild laxative. When this has been attended to, and the pain, fretfulness, and restlessness persist, a prompt resort to the tepid bath is advisable.—*Med. Record*, Oct. 4, 1890.

Lee (G. H.) on a Case of Tetanus Treated with Eserine; Recovery.—The patient was a woman of twenty-three, in whom tetanus supervened after a suspicious abortion, followed by exposure to wet and imprudent dissipation at a dance. Morphine, which, when given, was administered in large doses hypodermically, produced temporary and partial stupor, but had no action upon the tetanic contractions aside from what could be traced to the blunting of the sensory nerves, and thus the lessening of external irritation; but where the dose of eserine was sufficient to produce its effect, it thoroughly and promptly relieved the rigid convulsive symptoms and thus the pain. With the subsidence of the tetanic symptoms, the hypodermics of eserine produced its usual physiological effect in the violent symptoms noted; while when suffering from the tetanic condition, large quantities of eserine were exhibited with the most satisfactory, and with no unsatisfactory, results. Large quantities (gr. i. daily for eight or nine days) of eserine were necessary and were used.

The bichloride douche was applied to the uterine cavity. The patient had begun to improve before it was given; yet that improvement continued and was possibly more decided after the douche.

There is record of 149 hypodermic injections, and probably this is not all; yet there was never the least inflammation from any insertion of the needle.—*New Orleans Med. and Surg. Jour.*, Oct., 1890.

Potts (C. S.) on an Addition to the Therapeutics of Epilepsy.—The author, at the suggestion of Dr. H. C. Wood, has found more benefit accruing from the use of a combination of antipyrin and ammonium bromide than from the ordinary remedies used in the disease. No cures are claimed, but better results than from other medicines in the same cases.

About six grains of antipyrin and twenty of ammonium bromide are given three times a day.—*University Med. Mag.*, Oct., 1890.

Murell on Picrotoxin and its Uses.—The author calls attention to the therapeutical uses of "a useful but much neglected remedy," picrotoxin, an active substance obtained from the *cocculus indicus*. It has been recommended in epilepsy and chorea, and in certain forms of dyspepsia, megrim, and dysmenorrhœa. Externally it is used as a pigment or paint as a parasiticide, though one would scarcely have thought that there was a vacancy in this department. More to the point is its excellent effect in the sixtieth-of-a-grain doses in checking the exhausting night sweats of phthisis. In its action on the secretions, picrotoxin is allied to pilocarpine and muscarine, and is antagonized by atropine and members of that group. Since the drug is not devoid of poisonous properties in larger doses, it is well to know that its antidote is chloral hydrate.—*Med. Press*, Oct., 1, 1890.

Hare (H. A.) on Croton-Chloral in Neuralgia.—The great advantage of croton-chloral over chloral hydrate is that it relieves pain as well as produces sleep. The author claims it a safer remedy than is generally supposed, and says that while 5 grains will often relieve a neuralgia, 40 grains may be used without producing any more noteworthy effects than 20 grains of ordinary chloral so far as the heart and respiration are concerned.

The following case is of interest, as showing its advantages:

M. G., aged thirty-five years, has had, for over two years, a severe supra-orbital neuralgia, varying in intensity, and accompanied by roaring in the ears and loss of appetite and sleep. The cause of the neuralgia rests in the presence of middle-ear disease, with varying amounts of discharge. The Eustachian tubes are widely dilated and relaxed. The neuralgia is always worse when the discharge becomes in any way suppressed, and the branches of the entire trifacial nerve become involved in the painful neuralgic shootings. At this time it is impossible for the patient to go to the front door, as the noise of the street hurts her head so much as to make the pain unbearable. The loss of strength and flesh

was considerable, owing to the decrease in appetite and loss of sleep. Five grains of butyl-chloral hydrate were ordered every two hours in pill form. Six pills were taken, with entire relief of all symptoms and the attaining of good sleep and a better appetite. The effects of each dose lasted twenty-four hours, and then the pain required another six pills. She had no attacks for some weeks after this, although the ear was not discharging.

Functional insomnia resting upon no known cause also yields to this drug very well, but insomnia due to any advanced systemic lesion, as in phthisis, is not relieved in every instance under its use. The history of cases of phthisis who use the drug is that they sleep well the first night, and lie awake the second night to cough the lungs clear of mucus which has accumulated during sleep and while the nerves are obtunded by the drug. This second sleepless night can be quieted by a large dose, 20 grains, if desired, but I have never wished to run the risk of choking up the lung by preventing expectoration. In the neuralgia of phthisis and anæmia the drug is very serviceable.

Neuralgias of other nerves than the cranial are rarely benefited by butyl-chloral; but it is worthy of note that it may sometimes give relief in such cases by using with it 10 to 15 drops of the tincture of gelsemium.

In migraine, sick headache, and bilious headache, Ringer has recommended it, and in true migraine with hemianopsia it is certainly one of the most useful remedies along with antipyrine and caffeine, cannabis indica and gelsemium.

Curiously enough, while it cures the neuralgia due to a carious tooth, it does not cure toothache.

A great advantage possessed by croton-chloral is the applicability of moderate doses in cases of heart-disease.—*Med. News*, Aug. 30, 1890.

Adams (J. H.) on Marked Idiosyncrasy towards Quinine.—The patient was a man of twenty-eight with obscure malarial symptoms. Six grains of quinine were given at three P.M. At five the appearance of the patient had altered. He was covered from head to foot with a deep erythematous rash, extending even through his hair, over the palms of his hands, and especially marked on his tongue; the eyes were most markedly injected—so much so that it quite altered their expression, the whites being almost a uniform red color; there was also extensive œdema over the entire body—his face showed this especially, the bridge of the nose being puffy, with great bags of flesh below the eyes. Withal there were considerable nervous phenomena, his gait being so tottering that he could walk only with great difficulty; his hands trembled badly, and he suffered intensely from a severe headache. With the rash, there was an intense pruritus, so that he felt as if he could dig his flesh out in handfuls, this being most noticed on the scalp. An intense nausea prevailed, although there was no actual emesis, and he was considerably depressed throughout, and unable to talk very fully of his feelings. These phenomena had appeared a number of times before, each time after taking a small amount of quinine. At this time he had taken but six grains, and the symptoms had appeared within a few minutes after its ingestion, being at their full height within an hour. They lasted six to ten hours, and then gradually subsided, with apparently no ill effects being left in their train.—*Med. Age*, Sept. 25, 1890.

Phillips (J.) on the Analgesic Value of Antipyrin Intra- and Post-partum.—The author concludes: 1. That antipyrin in doses of fifteen grains repeated at proper intervals is a remedy of great value in the dilating stage of labor, and more especially in primiparæ, but that its uncertainty of action renders it less reliable than chloral. 2. That during the expulsive stage of labor it is useless as an analgesic, in whatever way it may be administered. 3. That in certain kinds of after-pains it is very efficacious. 4. That it is without any ecbolic properties, and has little or no effect on the frequency of occurrence of labor pains during the dilating stage, and does not aid dilatation of the os uteri. 5. That the effect of the drug appears to be more marked on impressionable and neurotic women and those of dark complexion and spare frame than on others. 6. That it should never be given by mouth without the addition of a diffusible stimulant.—*Lancet*, Sept. 20, 1890.

Duffus (J. C. G.) on Parotitis Caused by Antipyrin.—A young woman, suffering from influenza, had ordered for her some 10-grain powders of antipyrin. Immediately after swallowing one of these she experienced a feeling of suffocation,

and felt "as if a knife was being scraped along the tongue and palate." Then within ten minutes she called the attention of her friends to a swelling arising at each side of the face. I was sent for, and saw her within twenty minutes after the drug had been given, and found her in a very excited state, complaining of difficulty of breathing. The parotids on both sides were enlarged, as if the patient were suffering from mumps, and all within twenty minutes' time. The uncomfortable symptoms soon passed away, and by next morning the enlarged parotids had subsided.—*Brit. Med. Jour.*, Sept. 27, 1890.

Medical Treatment of Fractures.—In a graduation thesis in Havana an author discusses the advantage of prescribing various forms of phosphorus for patients suffering from fracture. He carried out a series of experiments on dogs and fowls by breaking the femur by means of an osteoclast, and putting up the limb in splints. He then divided the patients into two groups, the first group being treated with phosphorus in various forms, the second being left without medication. The result was that the callus was more abundant and firmer in animals treated with phosphide of zinc than in those treated with phosphate of lime, or than in those which were not treated at all. These results were confirmed by observations made in the surgical wards, where it was found that patients with fractures who took from a quarter to one eighth of a grain of phosphide of zinc daily made exceptionally good and rapid recoveries. The only unpleasant effects produced by this treatment were that one out of the eighteen patients on whom it was tried suffered from slight diarrhœa, and in one the pulse became slow and hard.—*Lancet*, Sept. 27, 1890.

Sahli on the Subcutaneous Injection of Water and Its Therapeutic Uses.—The author forcibly draws attention to a simple method of rapid and safe introduction of large quantities of water into the system. The method consists in the subcutaneous injection of a sterilized blood-warm physiological saline solution (that is, a 0.73 per cent. solution of chloride of sodium), by means of a large Erlenmeyer's flask, with an elastic tube and a hollow needle as thick as a knitting needle. As much as one litre of the solution can be easily injected in from five to fifteen minutes. If necessary, the procedure may be safely repeated four or five times a day. The best situation for the injection is the anterior abdominal wall. On each occasion the skin should previously be thoroughly washed with soap and corrosive sublimate, and the punctures subsequently sealed with aseptic cotton-wool and collodion. Under such precautions not the slightest signs of any local reaction are ever observed. In some patients, especially in those with flabby abdominal integuments, the procedure causes but trifling pain; in very sensitive or restless persons, however, general anæsthesia is advisable. The effects of the injections are thought to be as follows: 1. Under certain conditions they thoroughly wash out the patient's system by inducing profuse diuresis accompanied by a strikingly increased elimination of solid constituents of the urine. 2. They dilute the body juices and poisonous substances present therein. 3. They furnish the necessary water supply to dehydrated tissues. 4. They aid the filling up of blood vessels, and thus raise an unduly lowered arterial tension. Such subcutaneous injection of water is indicated: (1) In cases of uræmia complicating the course of either acute or chronic nephritis, where the injection of a litre of the solution once or twice daily is, as a rule, rapidly followed by a striking abatement of all symptoms. The best results, however, are frequently obtained when the injections are combined with the internal administration of digitalis. (2) In the "typhoid" state, where frequently even after the very first injection delirium ceases, the pulse becomes stronger and fuller, the tongue moister, etc. (3) In Asiatic cholera, cholera nostras, infantile diarrhœa. (4) In poisoning by any toxic substances, but especially by those which are liable to be eliminated from the organisms through the kidneys. (5) In cases where an internal use of water should be avoided (in order to secure physiological rest of the gastro-intestinal tract)—for instance, in cases of perforation of the stomach or bowel, peritonitis, ileus, etc. (6) In cases of acute anæmia from hemorrhage. The method is contra-indicated (1) in cases of incipient or expected pulmonary œdema; and (2) in the presence of severe dropsy.—*Brit. Med. Jour.*, Sept. 20, 1890.

Unna on Lanoline Ointments.—The author contributes a paper on the preparation of three ointments which have

not before been used owing to the great difficulties which have stood in the way of their application. As, however, the difficulties disappear when lanolin ointment is used as the base, the author recommends them to further renewed trials. The substances are sulphurous acid, hydrogen peroxide, and calcium chloride. It appears that anhydrous lanolin will only absorb about an equal volume of dry sulphurous acid, which is too little for practical purposes. The ointment is therefore made with a commercial solution of acid sulphite of calcium, containing about 5½ per cent. of sulphite and 5 per cent. of free SO_2. As soon as the sulphurous becomes converted into sulphuric acid (which has an irritating effect), it is decomposed by the sulphite present into sulphate and sulphurous acid gas. The ointment of hydrogen peroxide is made to contain between 40 and 56 per cent. of solution of the dioxide with a mixture of vaseline and lanolin (2 : 1) as base. This preparation is specially recommended for comedones, freckles, spots, etc. It seems, however, necessary to be careful in applying it to the face that the eyebrows are avoided, as the peroxide of hydrogen may change their color to a pale reddish-brown. For the ointment of calcium chloride a 33⅓ per cent. solution is used, of which the product contains about 60 per cent. An ointment containing about 10 per cent. of sulphur and 90 per cent. of a mixture of equal parts of lanolin, simple ointment, solution of calcium chloride, and solution of peroxide of hydrogen is found one of the best remedies against acne.—Berlin corresp. of *Provincial Med. Jour.*, Oct. 1, 1890.

MEDICINE AND PATHOLOGY.

Nias (J. B.) on the Value of Emaciation.—Emaciation is a prominent feature in many diseases. Many of the phenomena of disease are, in reality, efforts at repair. It will, therefore, be advantageous to inquire if some good purpose is not served by emaciation. To begin with diseases which affect the circulation. In many such we may note that the patient will rapidly lose flesh, and that when the loss has proceeded to a certain degree, it is arrested. The patient becomes and continues thin. Not only is it difficult to fatten him, but he is not much benefited by the attempt. Should his disease be arrested, but leave some injury behind, the patient will probably continue thin. Instinctively, in consequence, we look for the presence of disease, active or quiescent, in sparely developed persons. And, practically, we look for it in the territory of the circulation, either pulmonary or systemic, and generally find something. Such emaciation, ceasing at a certain point, does not much exceed what is seen in athletic training, and may be defined as an involuntery training, forced upon the patient by his ailment. What, briefly, is the benefit of training? Unusual effort in untrained men or animals is checked, not by muscular exhaustion, but by congestion of the pulmonary circulation and paralysis of the right ventricle of the heart. The effect of training is to enable the pulmonary circulation to keep pace with the increased activity of the systemic. Several changes concur to this end : dilatation of the lung and of its blood-vessels ; hypertrophy of the right side of the heart ; and most especially absorption of every tissue which is found to be superfluous for the effort in view. This absorption reduces the area of the systemic circulation ; and it is followed by a reduction in the quantity of blood, because a smaller quantity will suffice for active circulation through the lesser area. The individual so trained is in the condition of having a pulmonary territory larger than is necessary for his state of rest ; and, consequently, with a greater margin for relief upon exertion. Conversely, the contrary condition of obesity develops the systemic circulation to the full capacity of the lungs, so that the least exertion will produce dyspnœa. Acute disease being like exertion, we can see the advantage of entering upon it in a state of training. The exhaustion to be feared is that of the heart's right ventricle ; and the inconvenience of existing stimulants is, that they do not stimulate the right ventricle by itself.

To return to emaciation, as produced by disease. Let us first take the case of diseases of the lung. Should the territory of the pulmonary circulation be diminished by such a disease as phthisis, it would be impossible for the patient, without emaciation, to have an active circulation in the systemic area without danger of congestion of the lung. The feeble attempts that are made at hypertrophy of the lung in this

disease are thus met half-way. The same thing is true of all emphysema of the lungs, whether senile or morbid. Then we may consider the disorders of the greater circulation. In disease of the valves, when the muscle has to do the work of the valves, and in decay of the aorta, when the ventricle has to combine the aorta's duty with its own, the smaller the volume of blood to be dealt with the better. Without reduction of the area through which it flows, a reduced amount of blood would only result in a sluggish circulation. Emaciation in such cases is therefore salutary. Moreover, the capillaries are the seat of greatest friction; they are, therefore, the part to be reduced. This is the reason why all animals, in a state of nature, grow thin as they grow old. Man, and the creatures under his control, may violate this law, but not with impunity. Acute disease, when the arteries are decayed, is doubly dangerous. The right ventricle of the heart may be exhausted, as before, but now the left ventricle may also prove unequal. Stimulants here can have but little drawback. But in surplus lung, and an amount of blood that is well within the powers of propulsion, lies a greater safety. Obesity is dangerous to the aged.

It would be well to consider the phenomena of waste in fever by the light of an assumption that they are salutary. The brute creation, when suffering from fever, eat nothing, yet they do not die, but recover. The body seems destined to feed upon itself, and to delay all repair until convalescence. Great responsibility rests upon those who supersede this instinct by an artificial method. Graves, who fed fevers, at the same time bled his patients. Venesection has this drawback, that to relieve the right heart we are obliged to stint the left, and to reduce the systemic circulation to a sluggish flow. The speedy repair of such loss of blood shows that its benefit must be only temporary. Such a remedy is an imperfect substitute for a capacious lung. The perception of this inconvenience has led to the disuse of bleeding. The concomitant pressing of food in fevers should probably follow it. The most evident of natural remedies for any kind of fever are starvation and emaciation. However indulgent appetite may be in health, it returns in disease to the strictest authority. Obedience to its dictates may shatter superstitions, but will not jeopardize the cure. In chronic diseases, the physician who thinks of the future of his patient will look grudgingly on fat. It provides for warmth and irregularity of nutrition. If these be provided for in other ways, much relief can be given to the circulation; and if in acute disease the presence of a tissue should prove an embarrassment, the physician will not interfere with its removal.—*Lancet*, Sept. 27, 1890.

McLain on the Pathology of the Osseous Structure of the Teeth in Pregnancy.—The author refers to the great loss of the teeth in women as influenced by pregnancy. A strong acid reaction of the saliva and mucous secretions is an invariable accompaniment of the disorder. An acute sensibility about the necks of the teeth is followed by erosions near the margin of the gums, softening of the enamel, and ultimately the rapid disintegration of the dentine.

Defective nutrition is probably at the bottom of this pathological process, a part of the defective nutrition being the vitiation of the gastric, oral, and other secretions.

The obvious treatment consists in employing every hygienic means best calculated to build up the system, and control waste, as generous, wholesome diet, fresh air, exercise, mild tonics, and the exhibition of nervous sedatives when their use is indicated. Above all, the assimilative functions are to be encouraged by the administration of nutritive stimulants, of which nothing has given nore satisfactory results than the soluble phosphate-of-lime preparations, the hypophosphites, and particularly the lacto-phosphate in small doses, from 1 to 3 grains in solution, at each meal. The syrup of the lacto-phosphate is the most eligible form, except in the case of infants, when the powdered lacto-phosphate may be dissolved in the milk. Not unfrequently the most urgent dental tenderness and odontalgic symptoms with a tendency to decalcification of the teeth in pregnant women will entirely subside after the exhibition of this drug for a few days.

This treatment commends itself as much for the beneficial effects derived by the mother, as for the power it possesses of imparting to the child good dental structures. It is especially indicated if an hereditary predisposition to bad teeth exists in the mother, and should be carried

out with the view, not only of improving the structural quality of the teeth of the child, but also to mitigate the ills which are so common to the period of teething, a virtue this remedy possesses to an eminent degree, as I have had occasion to witness.

In the case of an infant its administration should begin early after birth, by dissolving the lacto-phosphate in the milk given from the bottle, and be continued in the ordinary food for a year or more after the first dentition shall have been completed. And where bad teeth are inherited, it would be well to continue it until second dentition has been well advanced. Minimum doses are preferable, as when larger quantities are given, a waste of the medicine is incurred, in consequence of the system not appropriating more than a certain amount. Two grains, two or three times a day, are therefore sufficient for practical purposes.

In the the case of pregnant women local treatment should not, in the meantime, be neglected. To this end the mouth should be rinsed with diluted lime-water or a solution of bi-carbonate of soda three or four times a day, and at night, just before retiring to rest, packing precipitated chalk about the necks of the teeth, for the purpose of neutralizing the acids that are so apt to accumulate at the margin of the gums. In the odontalgic pains of pregnancy I have had occasion to administer the syrup of the lacto-phosphate of lime, and have found it, in many instances, to act very beneficially—not only in relieving the symptoms, but frequently in curing them entirely.—*Occidental Med. Times*, Oct., 1890.

Wiglesworth (J.) on a Case of Ruptured Graafian Follicle, Producing Fatal Peritonitis.—Harriet A., aged twenty-four, was admitted into Rainhill Asylum on October 18, 1889. She had suffered from epilepsy since eleven years of age, and during the last year or two had had associated with the fit attacks of mental excitement, which had proved temporary; during the intervals between the attacks she was fairly bright and rational. She had menstruated regularly since the age of fourteen, and her fits were usually worse at these periods. She had not, however, menstruated since her admission into the asylum. Nothing of note occurred until January 7, 1890, when she complained of dyspeptic symptoms, foul tongue, and bad taste in the mouth. On the following day, not appearing so well, she was put to bed, and an examination revealed pain and tenderness in the hypogastric region. On the 9th the pain and tenderness had spread all over the abdomen; the temperature rose to 103.4° in the morning, and 104.6° in the evening, and the pulse was quick and wiry. It was clear, indeed, that the peritonitis had already become general. On the 10th the temperature fell to 101.2° in the morning, and 100.4° in the evening; but the abdominal pain and tenderness continued in spite of the free administration of opium. On the 11th a free menstrual discharge set in, and the patient appeared better. The improvement was maintained on the following day (the 12th), but on the 13th the menstrual flow stopped rather suddenly, and collapse set in. The abdomen was now much distended and tympanitic. The collapse gradually deepened, and the patient died on the evening of the 14th.

At the necropsy, which was made on January 16th, very acute peritonitis was disclosed, the intestines being glued together with recent lymph, and the pelvic cavity containing almost pure creamy pus. The right ovary exhibited on its upper surface a ruptured cyst the size of a large marble; the cyst arose from a broad base, and the orifice was likewise broad with somewhat jagged margins; a small, partly decolorized clot was attached to the floor. The cyst-wall was thin, and a microscopical examination by Dr. Thelwell Thomas showed no epithlial lining. It was, clearly, simply a ruptured Graafian follicle. Adjoining the large cyst was a small one, the size of a pea, with a similar protruding little clot. The remainder of that ovary, the left ovary, and uterus were healthy. There was no cause whatever discoverable for the peritonitis beyond the lesion just described.—*Lancet*, Oct. 4, 1890.

McArdle (F. E.) on Infantile Vulvar Hemorrhage.—Case 1.—On September 25, 1889, at two o'clock in the morning, I delivered Mrs. T. of her fifth baby, a girl. At my visit on the morning of September 30th, the nurse informed me that the infant had passed blood with every movement of the bowels since the preceding morning, and I was shown five napkins which were considerably stained with blood. I immediately examined the child and discovered that the hemorrhage came from the vagina

and not from the bowels. At the time of the examination there was about a half-teaspoonful of blood in the vagina and between the labia. This blood was bright-red, and the napkin was stained by it, showing that the flow was continuous. The anus was perfectly clean and healthy.

Borated absorbent cotton was ordered to be used and perfect cleanliness enjoined. At the end of the fourth day the hemorrhage ceased, and the child has since continued perfectly well.

Case 2.—On April 10, 1890, I delivered Mrs. C. T. of her first child, a girl. The labor was tedious, but in other respects normal. Five days later, at the morning bath, blood was discovered coming from the vagina of the infant. The same treatment was adopted as in the preceding case, and in four days the hemorrhage ceased.

It will be observed that in each infant the hemorrhage occurred on the fifth day after birth, lasted four days, and did not return.

The blood came from beyond the hymen and trickled between the labia. Whether it came from the vagina or uterus I am, of course, unable to state with any degree of accuracy, but it is my opinion that it came from the uterus. There was no malformation in either case.—*Med. News*, Oct. 18, 1890.

Kennedy (J.) on the Relation of Gonorrhœa to Renal Disease.—The author believes that gonorrhœa is a frequent causative factor in renal disease, and that among the sequelæ of this lesion nephritis is not rare.

The ways in which gonorrhœa may induce disease of the kidneys appear to me to be as follows :

1. By direct extension of the inflammatory process by virtue of continuity of structure.

2. By interference with escape of urine, as in stricture. The bladder, becoming filled, causes the urine to collect in the pelvis, calyces, and tubules of the kidney, and interferes with the process of secretion, causing congestion, which, if prolonged, the succeeding stages of inflammation follow, and a nephritis is established.

3. By reflex irritation. The urethral irritation may reflexly disturb the renal function and cause hyperæmia and congestion.

4. By diuretics. The excessive or injudicious administration of copaiba, cubebs, etc., so commonly used for the cure of gonorrhœa, may induce disease of the kidneys by overstimulation of these organs.—*N. Y. Med. Jour.*, Oct. 18, 1890.

Taylor (R.W.) on a Case of Second Infection with Syphilis, and a Case of Syphilitic Infection in a Person Hereditarily Syphilitic.—The first case was a sickly-looking woman, aged thirty-eight, who entered Charity Hospital in January last. Eleven years ago she had syphilis, having had hard swelling of the external genitals, enlargement of the glands, eruption shortly afterward all over the body, headache at night. The second year she had rheumatoid pains, mucous patches ; the third year serpiginous syphilides, etc. She married and gave birth to two weakly children, which soon died. Her husband dying, she again lapsed in virtue, and turned up in Charity Hospital in January last, broken down in health. There were typical miliary syphilides scattered over nearly the entire surface. All the ganglia were markedly enlarged. There were mucous patches of the tongue and mouth, and evidences of alopecia. She suffered pain in the joints, worst at night. The second attack was much more severe than the first. She was improving under mercurial treatment.

The second case was one of acquired syphilis in a person hereditarily syphilitic. The woman came to him first in 1879, aged nineteen, when he treated her for destructive syphilitic sore on the face, arising from hereditary syphilis, a clear history of which was afterwards given him by her mother, who acquired syphilis three months before the child's birth. The child had a rash, condylomata, sniffles, was weakly, etc. Five years after his patient's first visit, 1885, she returned, and had then macula roseola and scaling syphilides all over the body ; condylomata of the genitals, mucous patches of the pharynx, etc. The infection began in the right labium, and was contracted from the husband. The glands were all enlarged ; there was alopecia. She had since been cured.—*Med. Record*, Oct. 18, 1890.

Smith (A. H.) on Some Considerations in Regard to Acute Obstructive Diseases of the Lungs.—The author summarizes his considerations as follows :

1. In acute pulmonary obstruction, the danger being from exhaustion of the right

heart, the pulse at the wrist does not give reliable indications as to the gravity of the condition.

2. This can be appreciated more correctly by studying the pulmonary circulation by the aid of the pulmonary-valve sound.

3. Marked accentuation of the pulmonary-valve sound indicates a fairly vigorous right heart laboring to overcome resistance in the pulmonary circulation.

4. Decrease of a previously existing accentuation with only moderate dyspnœa indicates decrease of pulmonary obstruction.

5. Decrease of accentuation with increase of respiratory distress indicates that the right heart is becoming exhausted.

6. Relief is to be sought: *a*, by regulating the diet in conformity with the diminished power of digestion and sanguification; *b*, by the use of medicines which dilate the arteries and promote transference of blood to them from the veins; *c*, by the inhalation of oxygen gas; *d*, by artificial respiration; *e*, by placing ligatures about the extremities in order to retain the blood in them and prevent its return to the heart.—*Am. Jour. Med. Sciences*, Oct., 1890.

MISCELLANY.

Hypnotism in Belgium Declared Illegal.—The Chamber of Deputies has recently enacted certain laws rendering the practice of producing hypnotism illegal, except under certain conditions, and the practiser liable to fine and imprisonment. Whoever makes an exhibition of hypnotizing subjects renders himself liable to imprisonment for a period of from fourteen days to three months, and to a fine between the limits of 26 and 1000 francs. Any person, unless qualified as a medical practitioner, who hypnotizes any person under eighteen years of age, or any one of unsound mind, renders himself liable to one year's imprisonment and a fine of 1000 francs, even although the person hypnotized shall not have been exhibited. It is also an offence rendering the offender liable to imprisonment, to procure the writing or signature to any document conferring legal powers, and any individual making use of any document so made or signed renders himself liable to a like punishment. Is it not quite time such a law was enacted and enforced here?—*Med. Press*, Oct. 8, 1890.

Billroth on Resection of the Stomach and Bowels; a Personal Experience.—From November, 1879, until June, 1890, the author had performed 120 operations upon the stomach, including pylorectomies and gastro-enterostomies. Of those performed for cancer, 12 survived the operation and 15 died. Among the recovered, recurrence of the disease was noted at the end of five months, which proved fatal in different cases in 5 and 7 months, in 1¼, 2, and 2¼ years. Many are still alive, at the end of a year and a half.

Among the patients operated on for cicatricial contraction, one died a month after the operation from rupture of an abscess of the wall into the peritoneal cavity; and one, surviving five years, succumbed to a round ulcer. The others remain well. In three cases the diagnosis of the nature of the contraction was so difficult that it was necessary to make an exploratory incision into the stomach. These three cases died.

Of 28 cases of gastro-enterostomy for cancer of the pylorus operated on, 14 died. The survivors have lived from one to fourteen months.

Twenty-eight resections of the cæcum for cancer, or fistula, gave 12 recoveries. Eight resections of the colon gave 4 recoveries. Seven times was the rectum resected and no deaths were attributable to the operation. In only two cases was there union of the intestinal suture by first intention. In the other cases the posterior part of the suture gave way and an artificial anus was formed.

The author employs the interrupted suture of the mucous coat.

Collapse caused death in six cases of pylorectomy and nine cases of gastro-enterostomy. A septic peritonitis from escape of intestinal contents killed several, while the giving way of a suture, and consequent perforation, killed others.

Resection is most difficult in the lower extremity of the sigmoid flexure. The author has done this operation twice—one patient died in collapse, one lived five days. He has met with success in the last three rectal cases operated upon. He introduces three sutures, similar to those employed in the suture of nerves and tendons, and between these introduces sutures as near together as possible without producing gangrene.—*La France Méd.*, Aug. 29, 1890.

Dalton (H. C.) on Rupture of Liver and Kidney; Excessive Hemorrhage; Laparotomy; Recovery.—A robust mulatto of twenty-eight fell twenty-five feet, striking in the right lumbar region across an iron bar.

Great nausea and faintness developed, but he neither vomited nor lost consciousness. When admitted to the hospital an hour after the injury his temperature (rectal) was 100° F., pulse 84 and regular, respiration 38.

Pressure gave considerable pain over the right lumbar and hypochondriac regions. There was no abrasion or contusion at the site of the injury. The urine was drawn and found quite bloody. Percussion gave dulness over the right lumbar region as high up as the axillary line. I considered the dulness due to the hemorrhage, but did not know whether the blood came from the kidney or from the intra-peritoneal viscera.

As there was hæmaturia I thought its source was most likely renal. The patient's general condition was so good that I did not deem an operation advisable. He was given a dose of morphine and an ice-bag was applied to the right lumbar region.

At 10 A.M. the next day, 19½ hours after the injury, his temperature (rectal) was 102.2°, pulse 110, respiration 48. He had suffered considerable pain during the night, was very thirsty, and suffered considerably from nausea, though he did not vomit.

The abdomen was greatly distended and tender to pressure. Percussion elicited dulness (flatness) over both sides of the abdomen, extending well up towards the median line. The hæmaturia continued.

Believing that the hemorrhage was due to a ruptured liver, I proceeded to perform laparotomy. After thorough antiseptic precautions an incision was made eight inches long in the median line. When the first nick was made in the peritoneum a small stream of blood shot upward to a height of twelve or fourteen inches, due to the great intra-abdominal tension. The cavity was full of fluid blood, except in the right dorsal gutter and underneath the liver. At this point was found about a pint of dark clotted blood.

The belly was thoroughly washed out. To do this I introduced the hard rubber nozzle of a hose throwing a ¾ inch stream, connected to a large reservoir placed 10 feet above the level of the patient.

Passing my hand underneath the liver near its outer portion I discovered a large rent about three inches in length, into which I could place my index finger. Considerable blood was oozing from this wound.

As it was impossible to reach and close it by suture I resorted to the gauze tamponade. A double-handful of gauze was packed around the wound, the end of each strip left protruding from the upper angle of the parietal wound. The belly was closed by interrupted silk sutures involving skin, muscles, and peritoneum. Pelvic drainage was not used.

A remarkable feature of the case was that temperature, pulse, and respiration improved during the operation. As stated above, immediately before the operation the temperature (rectal) was 102.2°, pulse 110, respiration 48. Immediately after the operation, as soon as the patient was put to bed, the temperature (rectal) was 101.2°, pulse 100, respiration 22.

So that *during the operation* the temperature fell a degree, the pulse fell from 110 to 100, and the respiration fell from 48 to 22.

The improvement continued, the temperature never going above 100.5° after the operation. The gauze was removed on the second day. Hemorrhage did not follow its withdrawal. The hæmaturia ceased in two or three days, and the patient was discharged well August 23, 1890.

In looking back at this case I see where I could have done better in one particular. That is, instead of having the ends of the strips of gauze protruding from the upper angle of the median incision I should have made an opening in the lumbar region for this purpose.

Then, should hemorrhage have taken place, the fluid would not have had to overcome gravity, and the peritoneal cavity around this region would have been well drained.—*Weekly Med. Review*, Oct. 4, 1890.

Removal of the Pancreas for Cancer.—In an Italian medical contemporary a case of removal of the pancreas for cancer is recorded by Rugge. A woman, æt. fifty, came under treatment for gastric symptoms, loss of appetite, constipation, and pain radiating from the epigastrium in all directions. On examination, the author found a tumor between the umbilicus and left hypochondrium, hard, resistant, some-

what movable. The diagnosis was arrived at of a retro-peritoneal sarcoma. Laparotomy was performed, and the removal of the growth undertaken, a procedure which was by no means easy owing to the numerous adhesions which had formed. The growth was found to be the pancreas, the seat of primary carcinoma. The patient made a rapid recovery.—*Med. Press*, Oct. 1, 1890.

Battle on a Case of Trephining the Sternum.—The patient was a girl of twelve years.

During the autumn of 1888 she had been admitted for an ulceration over the upper part of the chest on the right side of the sternum. This, which was of a chronic, intractable character, was scraped, some of the underlying, softened bone being removed; it appeared at the time as if all the disease had been taken away, but the wound soon broke down again. On readmission there was a scar remaining from the old operation, which, in the form of a cross, extended from right to left of the sternum, just below the manubrium sterni. There was a sinus on the right side with granulating tissue around it, and another on the left presenting a similar appearance, through which a bent probe could be passed to the under surface of the sternum. The scar tissue was slightly tender, the sternum at this spot being bowed forwards, the two portions of bone being united only by granulating tissue. The child was pale and rather thin, but exhibited no other signs of disease. The family history presented no evidence of tubercular disease or syphilis.

The day after admission chloroform was given, and then ether. The patient took the anæsthetic very badly, the respiration being feeble at times, and the pulse weak; this condition was more marked when pressure was made over the sternum during the progress of the operation. An incision was made along the old scar down to the bone, and the flaps separated with the periosteal elevator. A bent probe passed for two inches under the sternum downwards, and in order to explore this track a crown of bone was removed with the half-inch trephine. The sternum was found much thickened. It was necessary to remove another inch of bone before the end of the sinus, which terminated under the cartilage of the fourth rib, could be thoroughly explored, the use of the gouge being insufficient. This sinus ran down a long track lined all round by granulation tissue, which was removed with the sharp spoon; the scraping of this sinus caused some faintness, and it was necessary to suspend the anæsthetic for a time. Chloride of zinc was used, and the cavity washed out, then iodoform was employed, and the wound partly closed with three silk sutures.

The patient had much vomiting afterwards, which lasted for twenty-four hours. A plug was kept in the upper part of the wound for some days, and when she was discharged there was only a small sinus, which healed later under observation.

Some months afterwards there was no return of the disease, which was of a tubercular character, and it was not possible to depress the sternum backwards at the point of the two halves of the bone.—*Med. Press*, Sept. 24, 1890.

Griggs (A. W.) on Chloroform the Remedy for the Albuminuria of Pregnancy.—The author remarks that since albumen is present in the urine in a large percentage of the cases of eclampsia, and that since the cure of the albuminuria gives all but absolute immunity against eclampsia, it behooves the physician to be on the alert, and if possible avert the coming storm; that this can be done without difficulty by the timely administration of chloroform per orem. The writer promises in a future article the explanation of the action of the drug in these cases. The plan of administration is to give doses of the drug suited to circumstances, as to the time you have for treatment, and the urgency of the symptoms. If it is six or eight weeks before term, begin with twelve drops and gradually increase up to fifteen or twenty. These doses are to be taken before each regular meal, or three times a day, and also at midnight. The drug is dropped into two tablespoonfuls of water, or more if desired, and the patient directed to hold the mouth and swallow promptly, immediately exhaling a portion of air from the lungs, so as to blow off the fumes of the medicine. If the urine is scanty, it will rapidly increase and the albumen diminish. The urine should be frequently examined and the chloroform continued as long as there is albumen to be found in the urine. It will be found that the digestion improves and the anasarca is relieved under the treatment. — *Southern Med. Jour.*, Aug., 1890.

Smith (S.) on the Prevention of Shock during and after Operations.—Long since, impressed with the dangers of shock in many modern operations, owing to the long continuance of the anæsthesia, the liability to chilling and to depression from the loss of blood, I have been accustomed, where time will permit, to prepare patients for operations by stimulation to the extent of semi-intoxication. The results have been most happy, especially with feeble patients whose condition has rendered the propriety of an operation very doubtful. The course which I pursue is to give the stimulant in hot milk, beginning from *eight to ten* hours before the operation. Such quantities are given, and so frequently, as to secure a state of happy indifference to the operation on the part of the patient. If the operation is to be at three o'clock in the afternoon, I give directions to commence at six or eight o'clock in the morning. I prefer whiskey to brandy, owing to its slow and persistent operation over a much longer period.

If the patient is not accustomed to the habitual use of stimulants I order an ounce of whiskey every two hours in half a pint of hot milk. If at twelve o'clock, or even at ten, sufficient progress has not been made to render it quite certain that semi-intoxication will be secured at the appointed time, I give an ounce of whiskey in milk every hour during the remaining time. When the requisite effect has been obtained the stimulation should be discontinued. In the case of habitual drinkers I have given two ounces every hour. It is important to give the stimulant in hot milk, which will furnish a large supply of easily digested and readily assimilated food, in a form most useful to sustain the vital energies during the critical period of a severe operation, or during a necessarily protracted operation.

The patient thus prepared has suffused eyes, a flushed skin, a slow full pulse, and complete indifference to the operation, though, perhaps, previously extremely timid. Frequently he jests and sings when taken to the operating table. He is warmly covered except on the part to be exposed for the operation. The assistant, who administers the anæsthetic, is directed to suspend it as frequently as possible. It will be a matter of surprise to any one who first administers an anæsthetic to a person partially, or quite, intoxicated by the foregoing means, to observe how quickly, and without a struggle, the patient comes fully under its influence, and how small the quantity required. The pulse remains at its normal standard throughout the operation, the breathing is quiet and regular, the skin continues warm and red and without unusual perspiration.

During the twenty-four to forty-eight hours subsequent to the operation the condition of the patient remains good. The pulse continues full, the skin natural, the respiration undisturbed, and the mental state is that of indifference, or hopefulness. Neither primary nor secondary shock occurs under such circumstances.

To prevent chilling, the patient should not only be protected by warm clothing, but the wound should be douched with hot water containing the disinfectant. The exact temperature of the water is a matter of much importance, as the term "hot" is indefinite and misleading. In the haste of an operation the hand is often employed to determine the temperature of the water. This test varies somewhat with different individuals, as one person will shrink from placing his hand in water at a temperature which another may bear with little inconvenience. I have frequently tested the temperature of water in which an assistant could thrust his hand, though compelled to withdraw it instantly. This temperature does not exceed 150° F., but more often is 145° F. The hand I regard as a sufficiently good test for a temperature of 145° F. to 150° F. Nor should I care to apply water at a higher temperature than 150° F. to the wound. The late Dr. Varick, of Jersey City, who urged the use of hot water, advocated using water "slightly" below the boiling point on operation wounds. Water at that temperature would, however, be destructive to tissues, for in my experience water at a temperature of 150° F. will destroy living tissues if it is allowed to remain in contact with them. It can be used at this temperature as a douche only—that is, it must be dashed on the wound. When applied to a fresh wound the surface should be rendered of a dull-gray color. The patient is usually instantly aroused by the heat. The best method of applying the water is by pouring from a pitcher, but not continuously; it should rather be dashed into the wound so that it will penetrate every

recess. The effect of the hot water is also seen in the arrest of all oozing of blood from the the wound, and this arrest of hemorrhage is permanent, and prevents secondary bleeding. The application of the dressings immediately follows, and as these consist of materials retentive of heat, there can be no chilling of the patient by the dressings.

During the past ten years I have pursued the above method of preventing shock, and in no instance has that complication occurred.—*Med. News*, Oct. 11, 1890.

Thompson (F. G.) on Gunshot Wound of the Heart, Lungs, and Stomach; Life Prolonged for Thirty Hours.—A man of twenty-three was shot August 10th at 11:55 P.M. with a pistol, the ball, a No. 32 calibre, entering the fifth intercostal space, nearly half an inch to the right of the left nipple. The wound was dry and the skin slightly darkened and inverted. He was seen at once, and was found to be quite anxious and able to stand. He was carried up stairs, and hypodermic injections of sedatives and styptics were employed. Pulse, 40; respiration, 9. Complained of thirst, and swallowed considerable fluid, but in an hour back and neck became stiff, and was unable to move. Rested quietly, and at eight o'clock next morning respirations were 16, and pulse 60. At eleven some clots of blood and tissue shreds were vomited, the abdomen began to enlarge, and he complained of pain and tightness, causing distress in breathing. At six P.M. respirations were 30, and pulse 100. His water was drawn off, but bowels never moved. Tuesday morning at six o'clock respirations were 70, and pulse 140, and he died forty minutes after.

A post-mortem examination made by the coroner, Dr. W. L. Whittington, assisted by several physicians, showed that the ball had passed through: (1) the lung about an inch and a half from the border; (2) the pericardium, and entering the left ventricular wall of the heart a little below the middle, passed out slightly to the right of the apex, very close to but not opening into the the cavity; (3) the diaphragm and the upper and left part of the stomach, going through the diaphragm again and striking the tenth rib below the ridge, about two and one half inches from the vertebræ, glancing along its surface and lodging between the tenth and eleventh rib, an inch and a half from the vertebræ. A large amount of fluid was found in the chest and abdomen, and considerable inflammation had taken place in the heart wall, the lower and left side of which was deeply injected, and the vessels filled with clots.

From the length of time he lived and the abdominal symptoms, it was supposed the bullet had deflected and passed downward, but post-mortem examination showed a perfectly straight course.—*St. Joseph Med. Herald*, Oct., 1890.

Skene (A. J. C.) on Injuries to the Ureters during Labor.—The author believes that many symptoms following labor are due to injury to the ureters. The discharge of blood and pus, in from three to five days after labor, may be caused by blocking up of the ureters on account of a pressure from the head of the child, or other conditions which may produce partial or complete closure. Acute disease of the kidneys may occur secondarily. The diagnosis of injury to the ureters must be made by excluding the ordinary puerperal affections. The natural tendency is toward recovery, but uræmia due to disease of the kidneys may prove fatal.

The following is a convenient classification of diseases and injuries to the ureters: 1, injuries of the ureters during labor; 2, obstructions of the ureters secondary to other pelvic inflammations; 3, obstructions due to neoplasms and uterine displacements. The second and third are taken from Englemann.

The conditions which predispose to injury of the ureters are: the bladder and terminal ends of the ureters resting low in the pelvis toward the end of gestation; defective nutrition of the ureters, with a consequent loss of elasticity and resisting power; pre-existing lesion, or functional derangement of the ureters.

The prevention of injury to the ureters is of greatest importance. The recognition of disease before parturition will ofttimes save much trouble. Free dilatation of the cervix, before rupture, insures comparative safety.

Treatment must be in a great measure expectant. Surgical treatment of these affections is not in a highly developed state. —*Med. Record*, Oct. 11, 1890.

Pyoktanin in Otitis.—Dr. Patryek, of Oppeln, has tried pyoktanin, the new aniline antiseptic, in several cases of suppurative ear disease, and has come to the

conclusion that it has little if any effect on the process of suppuration—at all events, in this class of cases. He mentions, besides, that the staining of the hands and clothes, which was unavoidable, was a very considerable drawback.—*Lancet*, Oct. 11, 1890.

Woodbury (T.) on Somnal, the New Hypnotic.—The first case in which I used somnal was in a patient suffering with acute alcoholism, who had been under treatment for a fortnight in an institution where he had a free supply of liquor, and he came out rather worse than he went in. He was thirty-nine years of age, very tremulous, and could not sleep, or if he dozed off would immediately waken up. I gave him, at about 3 P.M., thirty minims of somnal (or rather a drachm of a mixture of equal parts of somnal and whiskey), well diluted, and went into an adjoining room to speak to an attendant. Upon my return I was surprised to find him fast asleep, although I had not been away from him more than fifteen minutes. He slept for four hours, and then was able to take something to eat. At ten o'clock he had another dose, and he slept until seven the next morning, having wakened up once only during the night and insisted upon having another dose, and immediately after taking it he fell asleep again. The next night he was given a double dose at 10 P.M., and slept all night without wakening. No bad effects were observed. The somnal was given for four nights, when he was so nearly well that it was suspended, as he had had good natural sleep at night and seemed quite restored. Alcohol was positively prohibited, the only substitute allowed being elixir of cocoa and camellia, in tablespoonful doses, in which, it is true, there was a small amount of alcohol, which was quite infinitesimal when compared with what he had been using. Somnal, therefore, acts well in acute alcoholism as a tranquillizer and hypnotic.

In a case of neuralgia of the bowels (visceral neurosis of Allbutt), where the patient had a sleepless night, a dose of twenty minims relieved nausea and pain, and the patient fell asleep.

In syphilitic headache and insomnia, somnal in moderate doses failed to produce sleep which was afterwards secured by potassium bromide and iodide and antipyrine.

In cases of insomnia, fretfulness, and restlessness in young children, somnal with mint water and syrup offers better results than opiates, and is much safer. The same remark probably applies to the use of somnal in acute pneumonia, but I have not been able to confirm this yet by actual trial.

Without further going into detail, it may be stated in conclusion that somnal acts as an hypnotic, but instead of depressing the system as chloral does, it slightly stimulates the gastric mucous membrane, relieves nausea and pain, improves the appetite, increases secretion (probably), does not cause constipation. The circulation, respiration, and temperature are not notably depressed after its administration. No disagreeable after-effects have been observed. As it is rapidly eliminated from the body it may be administered each night for a number of days without any obvious ill-effects. It acts very much like chloral, but is more pleasant to take and not so depressing in its effects upon the nervous system and the circulation.—*New Eng. Med. Mo.*, Oct., 1890.

Smith (A. L.) on the Local Administration of Bichloride of Mercury in Certain Diseases of the Female Pelvic Organs.—I have now been employing the local administration of bichloride of mercury in doses of one tenth of a grain every three or four days, on a boro-glyceride tampon, during the last two years, about five hundred times in about fifty cases of vaginitis, endometritis, salpingitis, ovaritis, and pelvic peritonitis, and I feel sure the duration of treatment, before relief has been obtained, has been very much less than was the case before I adopted this method. Exactly how much of my success is due to the bichloride alone, I am unable to say, for the simple reason that, at one time or another of the treatment, in every case, I employed other remedies and measures in addition to it. One of my reasons for attaching so much value to the bichloride of mercury employed in this way, is that nearly every one of the diseases above mentioned is due more or less directly to septic absorption, and that the more or less constant production of septic matter is necessary to keep up the disease.

The method in which I prepare these tampons is as follows: I make seventy of them at a time of different sizes, from the best absorbent cotton, which I then plunge into a pint of distilled water colored with aniline dye, and in which a seven-grain

bichloride tablet has been dissolved. If a pint is too much or too little, less or more water may be added; but I find that a pint can be taken up quite easily by seventy of these tampons. Each tampon will, therefore, contain one tenth of a grain of bichloride. Care must be taken that too strong a dose is not employed, otherwise the discharge becomes irritating to the mucous membrane of the vulva. I employ these tampons in every case in which tampons are required, sometimes using as many as three or four of them, either dry or after soaking them as well, in either glycerine or ten per cent. boro-glyceride. Although I believe that this quantity is quite sufficient to have a very material effect upon the germs of putrefaction, as well as on gonococci, the dose is quite harmless, there not being at any time in the vagina more than an ounce of a one in ten thousand solution, or one half an ounce of a one in five thousand. I have noticed in every case in which I have employed them that the unpleasant odor of the discharges, of which the patient had previously complained, has been completely removed, which alone would be enough to make it well worth while employing them. Another advantage is, that tampons so prepared may be left from four days to a week without decomposing, which is greatly to be desired in cases which cannot be seen by the attendant every two days. I rarely, if ever, use pessaries, as I find, especially in cases where there are adhesions, that these tampons are painless, never light up inflammation, and are very effective in keeping the uterus and ovaries in healthy position until the cause of the displacement has been removed by other means.—*Canadian Practitioner*, Oct. 1, 1890.

Application of Mineral Acids in Necrosis.—According to Dr. Ole Bull, who writes in a Norwegian medical journal, the suggestion of an English surgeon, to employ sulphuric acid containing a certain amount of sulphurous acid to loosen necrosed portions of bone is not altogether good, inasmuch as sulphuric acid forms sulphate of calcium, which is insoluble and opaque, and so prevents the acid from acting on the deeper layers, besides obstructing the view. He finds, however, that some of the other mineral acids act very much more satisfactorily. After a good many trials he has come to the conclusion that the most suitable application is a 4-per-cent. solution of hydrochloric acid, which he has used very successfully for necrosis and caries of the temporal bone. This forms a soluble salt of lime, and is well tolerated by the external meatus, and even by the cavity of the tympanum. In cases where polypi had been removed by means of galvanocautery or by chromic acid, treatment of the stump by hydrochloric acid was very successful, but it was necessary to continue the applications for about three months.—*Lancet*, Oct. 11, 1890.

McGuire (H.) on Nervous Disorders Following Organic Strictures of the Urethra.—The author relates a number of cases in which paralysis, apoplexy, or cerebral disease of some kind followed long-standing stricture. In some of these cases there was renal disease. In his practice he had seen sclerosis of some portion of the spinal cord follow old strictures. He concludes the paper thus: "Are all of these cases mere coincidences? Urethral strictures are so common, and diseases of the nervous centres so frequent after middle life, and the interval of years between the formation of the stricture and the appearance of nervous troubles so great that it is difficult to say that one is dependent upon the other. As it is, however, I cannot help thinking that long-existing urethral strictures may set up reflex irritation in one or more of the nervous centres, and this persisting ends in pathological change in one form or another."—*Med. Record*, Oct. 18, 1890.

Donkin (H. B.) on Gastric Ulcer and its Treatment by Enemata.—The patients treated by the author all did well with fluid enemata, mostly untreated by any digestive agent. From an experience of many cases other than those detailed, some of which he has treated with peptonized fluid enemata, some with simple fluid enemata, and a few with suppositories, he is confident that those who have the simple fluids, such as milk, or milk and beef-tea, do every whit as well as the others. All the patients, whatever rectal alimentation they receive, waste more or less, some considerably, but they recover flesh as quickly. It is striking that there is apparently no difference between the results of treated and untreated enemata, and as in a large majority of his cases he gave absolutely nothing, not even ice, by the mouth for many days, he always now

uses fluid enemata, deeming suppositories in such instances quite out of the question. He has never made the experiment of using injections of water alone, but thinks it might justly be tried in the case of a patient not in a hospital. There is certainly grave physiological doubt as to whether any albuminous substances, however treated, are assimilated after rectal "feeding," and it has been amply demonstrated by fasting folk that man can live for many days on water alone. He regards absolute rest of the body as an important aid to quick recovery. He has scarcely ever any trouble about the retention of enemata. They should never be large, but may vary from two to three ounces as a rule, the frequency of repetition being decided in each individual case. The rectum should be washed out when any irritative symptoms appear, and opium will then seldom be necessary. The lesson to be derived from consideration of such cases as these is that there is no difficulty in keeping most patients on fluid enemata for some weeks; that in all cases where the symptoms are masked, such treatment is imperatively demanded at once; that even in doubtful cases it is very often advisable, though very small and frequently repeated quantities of milk, etc., by the mouth may often be tried with success, and are thus obviously preferable; and that drug treatment of any kind is scarcely ever of any use, and would be, as a rule, contra-indicated. After the resumption of solid food, nutrition is apparently aided by the administration of arsenic and iron for some time. From time to time, and especially in cases which are fed by the mouth on milk throughout, evacuation of the lower bowel must be effected by means of simple enemata, and the rectum should never in any case be allowed to remain or become loaded.—*Lancet*, Sept. 27, 1890.

MacDonnell (R. L.) on Cardiac Complications of Gonorrhœal Rheumatism.—In the Montreal General Hospital there have been of late twenty-seven cases of gonorrhœal rheumatism; of these there were six cases in which cardiac physical signs were present, but in three of these a history of rheumatism or scarlet-fever could not be excluded. Two others had undoubted gonorrhœal rheumatism, and heart murmurs were found when the patients were admitted. In the sixth case cardiac symptoms were present at the outset. The patient, who was suffering from gonorrhœa, was exposed to cold. Slight joint pains were present, followed by urgent dyspnœa and pericarditis. Endocarditis and pleuritis subsequently.—*Canadian Practitioner*, Oct. 1, 1890.

Nankivell (J. H.) on a Rare Complication of Gonorrhœa.—Abscess of the corpus spongiosum as a complication of gonorrhœa is rare. Such a case has recently come under my treatment, there being no history whatever of a bruise or any other cause to account for it except the gonorrhœa. This abscess was situated about the middle of the penis, extended on both sides of the urethra, and contained about two drachms of greenish-yellow pus. It did well under treatment, but if the pus had been allowed to make its way into the urethra or externally into the loose cellular tissue a more serious result would have taken place.—*Lancet*, Oct. 1, 1890.

Roux and Yersin. Researches on Diphtheria.—The authors have contributed various papers on this subject to the *Annales de l'Institut Pasteur* in the last two years. The practical deductions from their labors are as follows:

"The best method of arresting the spread of diphtheria is to recognize the disease as early as possible; consequently a precise diagnosis should be made by microscopic examination of the false membranes, and this should be confirmed by cultivations on blood serum," as the former takes only a few minutes, and as the latter gives results in twenty-four hours, both these methods are available in private practice or where patients can be sent to an observation ward.

"Active diphtheritic virus can remain in the mouth for a long time after the malady is cured. Consequently diphtheritic patients should only be allowed to resume their ordinary course of life when they are no longer bearers of the bacillus.

"Diphtheritic virus retains its virulence for a long time when kept in a dried state. It is therefore necessary to disinfect in a steam sterilizing apparatus the linen and all articles that have been in contact with diphtheritic patients.

"The attenuated virus of diphtheria is widely distributed, and it readily regains its virulence. It is therefore necessary at the very commencement of simple forms of throat disease, and of those associated with measles and scarlatina, to practice

careful and frequent swabbing of the throat with antiseptics."—*Brit. Med. Jour.*, Sept. 27, 1890.

Ullmann (E.) on Colorectostomy.—This is an operation which the author has devised for the relief of cases of rectal cancer where the growth is high up and inoperable. By an incision in the left flank he exposes the sigmoid flexure of the colon, brings it down into the pelvis and forms an anastomosis between it and the rectum below the growth, in this way diverting the fæcal current past the cancerous and perhaps strictured portion of the gut. —*Annales et Bull. de la Soc. de Méd. d'Anvers*, June, 1890.

Broadbent (W. H.) on New Drugs.—Towards the close of an address "on therapautics as an applied science," the author says: "One more protest I must raise; it is against the rage for new drugs which seems to have taken possession of the profession. This is absolutely fatal to accuracy of observation and precision in treatment. When the action of a remedy has been worked out by such a man as Professor Fraser, we welcome it at once, as was the case with strophanthus, and the entire medical world owes him a debt of gratitude; but when the drugs are recommended simply by an advertising chemist, it is humiliating to see their statements command general acceptance. Podophyllin is said to act on the liver, and so is calomel, but can any one who has given a moment's serious thought to the subject, or who has observed closely the effects of his treatment, suppose that a dose of podophyllin is the equivalent of a dose of calomel? I often wonder what we should have said if, having podophyllin and iridin and cascara, we had discovered rhubarb and aloes and senna.

Am I not right in my conjecture that they are most ready to fly to new medicaments who have least knowledge how to use the old and tried ones? May I take the dangerous liberty of indicating the points of my diagnosis of a weak medical man? They are: indiscriminate administration of stimulants in fever, a ready resort to narcotics and sedatives, treatment directed to symptoms only, and a fondness for new drugs with high-sounding names. —*Brit. Med. Jour.*, Aug. 9, 1890.

Staple (J. D.) on Oil of Wintergreen.—This oil consists of 10 per cent. of a peculiar volatile hydro-carbon called gaultheriden, and the remaining 90 per cent. of salicylate of menthol. I have used the oil of wintergreen as a local application in subacute and chronic cases of rheumatism for nearly four years, and am highly satisfied with the results. During my two years' house-surgeoncy at Stockport Infirmary I used a liniment composed of equal parts of oil of wintergreen and olive-oil in forty cases of subacute rheumatism. After this was applied the joint was wrapped in cotton-wool and lightly bandaged, and the patients stated that the pain generally ceased in from five to six hours after its application. It is in the more chronic cases of rheumatism, however, that the oil of wintergreen is the most useful; and although I have used it in over one hundred of these cases, I have notes of only two patients who did not experience any relief from the liniment. I should add that in these chronic cases it is most essential that the liniment should be thoroughly rubbed into the affected parts. I first read of the oil of gaultheria as a local application in an American journal, and tried it in a few cases, which I reported, and I see in Martindale's and Westcott's extra Pharmacopœia for 1890 that my short note in the *British Medical Journal* on the oil of wintergreen as a local application is the only one mentioned under that heading.—*Lancet*, Aug. 30, 1890.

Axtell (E.R.) on the Use of Bichloride of Mercury in Typhoid Fever.—In seventy cases of typhoid fever treated at our hospital last year, thirty-six were placed entirely upon the bichloride of mercury, one-twentieth of a grain three times a day in a half glass of water, and some stimulation, in the form of whiskey, in all cases with any marked prostration. This was faithfully followed out, and under its use we had in our thirty-six cases but two deaths, one of these being a case of advanced Hodgkin's disease, the other a case of melancholia with great fright, which patient we lost from profuse hemorrhage due to the fact that he could not be kept in bed.

The percentage is thus honestly reduced to almost *nil*, and I think it but fair to claim for the treatment, that under it the percentage of deaths is lessened, for in thirty-four cases on different treatment, nine died; and even if three of them be eliminated, as I have done before, still there is a large balance as against the

thirty-six cases with no deaths. Under this treatment there is lessened mortality, shorter duration, less tympanites and furred tongue, fewer complications, and more rapid convalescence.—*Denver Med. Times*, Aug., 1890.

Fischer (L.) on the Treatment of Pertussis by Bromoform.—The doses of bromoform given by the author are as follows: For children under and up to one year of age, two to three drops three times a day; children from two to four years of age, three to four drops three or four times a day, depending on the severity of the case; children until eight years of age, four to six drops three or four times a day.

The doses were usually increased on the third day, sometimes after the fourth day of treatment, and in very severe cases on the second day of treatment, by gradually adding one drop to the usual dose. The quantity ordinarily required for a cure was from 10 to 15 grammes, although sometimes 5 grammes was enough; in severer cases 20 grammes, and even more, was required. Owing to its extreme volatility, it was difficult in most cases to exactly determine just how much bromoform had been used. The time required for a cure was variable; in some cases ten days of treatment was enough to effect a cure; others required almost four weeks. About 75 per cent. could be discharged cured between two and three weeks after steady treatment, where no other complications existed.

Bromoform should be given in a small teaspoonful of water. Owing to its weight it sinks to the bottom of the spoon, and great care must therefore be taken to see that the child swallows the bromoform, and that it does not remain in the spoon. There is no difficulty in giving it to children, as bromoform has a pleasant taste and was very readily taken by such patients.—*Med. Record*, Sept. 6, 1890.

The Active Principle of Jequirity.—A Dutch observer, Dr. Nicolai, has been engaged in a series of observations directed to the elucidation of the question whether the irritant action of the seeds of the Abrus precatorius, or jequirity, is due to a non-organized ferment or to bacteria. He found that, while a pure culture from the seeds produced no irritation of the conjunctiva, a chemical preparation in which there were no bacteria set up the inflammation characteristic of jequirity. He concludes that the active body is an amorphous ferment or "entyme," which can be isolated in the form of a white powder. This substance caused conjunctivitis in four or five hours. Its activity was destroyed by a temperature of 180° C. when dry, but a three-per-cent. solution became inactive after being heated to 78° C. It was also rendered inactive by borax and by prolonged treatment with absolute alcohol. Chloroform, ether, and corrosive sublimate did not affect it. No resemblance could be traced between it and pepsin rennet or diastase. It appeared to have strong toxic properties, for, when injected into the venous circulation in rabbits it rapidly proved fatal, causing convulsions and paralysis of the heart.—*Brit. Med. Jour.*, June 7, 1890.

BOOK NOTICES.

A Guide to the Diseases of Children.—By James Frederic Goodhart, M.D., F.R.C.P. Rearranged, revised, and edited by Louis Starr, M.D. Philadelphia; P. Blakiston, Son, & Co., 1889.

This is the second American edition from the third English edition. The work has been revised throughout, but has undergone no material alteration. Some slight rearrangement has been made in the earlier chapters, and the directions relating to diet in infancy have been amplified. Recent methods of treatment have also been inserted.

The type and paper are very good, and the excellent style of the writing delights the reader.

In the introduction the author treats of observation, examination, and diagnosis. He gives many good points as to what to avoid and what to do in the examination of a child. General remarks on dosage and treatment follow. The last twenty pages of the introduction are devoted to considerations of diet. All the latest methods and formulæ are mentioned, though not with that detail that one could wish from so eminent an authority on so important a subject.

Part 1 consists of the Diseases of the Digestive System. Some of the subjects considered are rarely found in the general text-books on Pædiatrics. Such are Chronic Tonsillitis and Hypertrophy of the Tonsils, Relaxed Throat, and Ulcer of the Stomach. "Diarrhœa" is divided into three varieties:

a. Simple Diarrhœa,
b. Febrile Diarrhœa,
c. Cholera Infantum.

Of Febrile Diarrhæa the author says: "This is a common affection in American cities during the hot months. It chiefly affects children in their 'second summer,' and those belonging to the poor, who are doomed to pass the hot months in crowded, ill-ventilated, and filthy localities of large cities." The synonyms given for "Febrile Diarrhœa" are "Entero-colitis," "Summer Diarrhœa." From this paragraph and what follows, in the dissussion of this disease, it may be inferred that American chil-

dren are herein greater sufferers than their British cousins. "Cholera Infantum" is defined as "the analogue of cholera morbus in the adult." The distinctive features are described to be "the character of the stools (very large, watery; or containing flocculi; or composed of dirty-brown liquid), the extreme irritability of the stomach, intense thirst, high temperature, disturbed respiratory rhythm, and rapid emaciation and collapse." "There is a certain resemblance between this disease and sunstroke, but the two conditions have little in common beyond the fact that they both occur in hot weather." The definition of Cholera Infantum is certainly unfortunate, for Cholera Morbus in the adult is a vague name, differently interpreted by different authors and by different nationalities. Delafield, of New York, calls Cholera Morbus an "acute Gastro-enteritis, varying in symptoms according to the extent of the alimentary tract which is involved." Loomis says: "Cholera Morbus, called also *cholera nostras*, *English cholera*, and *sporadic cholera*, is in reality idiopathic entero-catharsis. If any anatomical lesion exists, it consists in an acute gastro-enteritis; but the disease may occur without any discoverable lesions, thus simulating a functional disorder. It is so rarely fatal that there has been little opportunity to study its morbid changes."

The author, under diseases of the intestines, also treats at some length of "Abdominal Neuroses," among which he places the "Mucous Disease" of Eustace Smith. The American editor, Norvin, inclines to the opinion of Smith.

Of the book as a whole, it may be said that it gives many valuable observations from an authority on which one can place reliance; but that it does not stand as a complete treatise on children's diseases. The rare subjects brought in will especially commend the work to the practitioner; and the agreeable and concise style, and the form of selection for description of the striking features of a disease, will always make Goodhart, edited by Starr, a welcome book to students. E. S. B.

Intestinal Diseases of Children.—By A. Jacobi, M.D., 1890. G. S. Davis, Detroit, Michigan.

These two little volumes will be cordially welcomed by the profession, for they present in compact form the mature experience of an eminent authority on one of the most important divisions of Pædiatrics.

Dr. Jacobi was induced to make the digestive organs of infants and children the subject of this manual for two reasons: *first*, because he believes that diminution of early mortality depends upon avoiding diseases of the digestive organs by insisting on normal alimentation; and *second*, because the hygienic rules for infants concern the digestive organs mainly—so much so that infant hygiene, and the hygiene of the digestive organs in infants, appear to be nearly identical.

More than half of the first volume is devoted to alimentation of the child in health, and treats of alterations in breast-milk; diet of wet-nurses; substitutes for breast-milk (with all the modes of preparation); how to feed; and nourishment succeeding the period of infancy. In these chapters one is somewhat surprised to find no reference to sterilizing milk for infants' food. Boiling is recommended, and "any apparatus is good enough for the purpose." The only explanation of this seems to be that the pages were written (the introduction is dated October, 1889) before sterilizing milk was a recognized procedure.

The distinguished author indulges in four pages of criticism upon the artificial foods offered for sale, what he characterizes a "growing evil, which has assumed vast proportions." He adds: "No profound thinking is required to appreciate the fact that of a great many of the articles offered for sale a few only are available compositions. But the very fact that they are compositions that every thing organic may spoil, that every compound depends on too many circumstances which are apt to interfere with its uniform condition, and that when we rely on a compound we rely at the same time on a proprietor, his foreman, his workman, his chemist, and the wholesale or retail dealer, we feel that we are easily deceived or disappointed. Besides, for an article, the constituents of which we can purchase at a low price, we are taxed to an inordinate extent."

Under Dentition, the author reiterates forcibly what he has so ably defended in other writings, that the eruption of the teeth is a physiological process, and if morbid phenomena appear about that time, some other causes must be sought. For at about this time changes in the glands of the digestive tract are taking place; the child is more exposed to atmospheric influences; rachitis, which is increasing in this country, is developing; and the nervous system is especially unstable.

When diseases of the intestines are entered upon, the writer deals at some length with the details of the physiology of digestion and the functions of different parts of the alimentary tract. In the anæmia of gastric diseases, caution is urged in the uses of iron, and the *liquor ferri albuminati* is recommended. All through the volumes are found those practical and well-explained suggestions as to treatment which have always characterized Dr. Jacobi's writings. He says: "The combination of cod-liver oil with phosphate of lime is based on an illusion concerning its alleged efficiency," because "as long as the food contains plenty of calcium and phosphoric acid there is no indication for the introduction of the same as medicine."

Under the various forms of intestinal catarrhs described, one should look for the author's opinion upon lavage of the bowel. But there is found nothing until under Ulcerations of the Intestines. He says that "the local treatment of intestinal ulcerations requires the use of enemata," which are described in some detail.

In speaking of Perityphlitis the author lays stress upon the fact "that it is rarely that a post-mortem examination is made after fatal typhlitis without exhibiting the signs of previous inflammation in the immediate neighborhood of the process. Diarrhœa, intense constipation, dysentery, typhoid fever, are ample causes of a local peritonitis." All Dr. Jacobi has to say about the operative treatment, which is now attracting so much comment, is: "When the diagnosis is clear, there is no objection to an antiseptic puncture. . . . When pus is formed, an incision must be made at once, and the parts drained."

While the author leaves untouched several points on which we wish he had written at least a brief paragraph, the student and practitioner are enriched by what both will concede to be a most valuable monograph. E. S. B.

THE MEDICAL ANALECTIC AND EPITOME.

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE.

EDITED BY R. W. AMIDON, M.D.

VOL. VII., NO. 11. November, 1890. WHOLE NO. 163.

THERAPEUTICS.

Aristol.—We are now being enlightened, chiefly through trade circulars, about a new drug, aristol, for which are claimed antiseptic properties without untoward or poisonous effects of any sort.

The drug is a brownish, amorphous, odorless powder, resulting from the addition of a solution of iodine in iodide of potassium to an alkaline solution of thymol.

It is insoluble in water and glycerine, slightly soluble in alcohol, but very readily soluble in ether, chloroform, fatty oils, and vaseline. Solutions should be made and kept cold, and also protected from the light, as heat and light decompose both crude drug and mixtures.

It is claimed to have a local action similar to iodoform, with the advantages over the latter that it is odorless, non-irritating, and non-toxic. It does not stain the skin or cause conjunctivitis as does chrysarobin.

It is claimed that the processes of granulation and cicatrization go on under its employment with extraordinary rapidity. Sometimes it is found a little too stimulating. Applied as a powder it is very adhesive and acts partly as a protective.

It quickly destroys fetor, but no one claims that it has the anæsthetic action of iodoform.

It produces no iodine reaction with starch, but the discharges from wounds dressed with it do affect starch, showing that such organic fluids probably do set free some iodine.

It should not be mixed with caustic alkalies, alkaline carbonates, metallic oxides, or corrosive sublimate, as they promptly decompose it.

It is employed in various ways: dry in powder (pure or diluted), where its stimulant, absorbent, or protective effect is wanted; in solution in ether, or collodion chloroform; in oil or ointment.

It is claimed to be curative in many skin diseases, particularly the various mycoses. Space only allows a simple enumeration of the various affections claimed to be benefited or cured by it:

Psoriasis, lupus, various forms of eczema, ringworm, scabies, sycosis, scrofuloderma, condylomata, intertrigo, erysipelas, bromide eruption, and chromophytosis.

Varicose ulcers, ulcers of tertiary and congenital syphilis, gangrene of skin, specific bubo, mucous patches, epitheliomata, and hard chancres.

Chronic urethritis of prostitutes, chronic urethritis (prostatic) in the male, erosions and ulcerations of the cervix, endometritis, and metritis.

Pharyngitis, laryngitis, rhinitis, ozæna, subacute and chronic otitis media, chronic conjunctivitis, etc., etc.

While some claim good effects from its use in soft chancre, most authorities deny altogether its usefulness in that affection.[1]

No one claims it as curative in gonorrhœa, and it has been experimentally shown to have no germicidal effect on the gonococcus.

Van Baelen on the Use of Aristol in Dermatology and Gynecology.—In old atonic ulcers it acts like iodoform, diminishing secretions, deodorizing the diseased surface, hastening cicatrization, and favoring the development of healthy

[1] In the ANALECTIC AND EPITOME for September, 1890, p. 402, Eichhoff was erroneously quoted as recommending it as useful in chancroids.

granulations. Tubercular ulcers are improved by the drug.

In a large varicose ulcer of the leg in an old alcoholic, a manifest tendency to erysipelas was checked by the powdered drug.

A phagedenic ulcer of the penis was not helped by the application.

It lacks the anæsthetic quality of iodoform.

In its use in psoriasis and eczema the author was disappointed, it proving useless, as it also did in lupus and epithelioma.

In vaginitis and cervicitis it acts well applied in oily solution on cotton tampons. In endometritis and metritis it is useless.—*Ann. et Bul. de la Soc. de Méd. d'Anvers*, Aug., 1890.

Kinnier (D. F.) on Aristol in Affections of the Skin.—The author has experimented with aristol in skin affections, and gives the results of his experiments in ten cases.

In a case of lupus erythematosus healing progressed with the production of a flexible cicatrix. A case of lupus exulcerans faciei was doing well when reported. It seemed to have no good effect on a case of sclerous lupus. A varicose ulcer healed under its use in two weeks. Psoriasis vulgaris was cured in ten days to two weeks. Tinea versicolor and erythema intertrigo disappeared in a few days. In two cases soft chancres healed under its use, in one case iodoform had to be substituted before healing took place.—*Med. Record*, Oct. 18, 1890.

Martin (E.) on Aristol.—I directed one of my students, Mr. R. Pittfield, to record carefully the results of its employment as a dusting-powder in a comparatively large number of selected cases. It is difficult to tabulate accurately the results obtained in these cases, and no just judgment can be formed of the drug until its use is much more widespread than at present. In general terms it may be stated that the observed effects were very similar to those noted after the employment of iodoform. The wounds and open surfaces remained dry, granulations were slightly stimulated, and healing progressed favorably. Good effects were particularly marked in several cases of ulcerating gummata. In these there was pronounced improvement immediately upon substituting aristol for iodoform.

In but two cases was there any ill effect from the powder. In these granulations, which previously had been comparatively healthy, became highly inflamed and slightly sloughing, so that iodoform had to be used.

As a result of the application of aristol to a variety of cases it would seem that the drug may be fairly ranked with iodol, hydronaphthol, and iodoform in so far as its immediate effects are concerned, that it is particularly serviceable in cases of ulcerative syphilis, and that it possesses the advantage of being devoid of disagreeable odor. As to whether it can by decomposing in foul wounds render septic products innocuous is yet to he determined, and upon this point will depend either its universal use or its relegation to the obscure position occupied by so many drugs which have been advocated from time to time.—*Med. News*, Nov. 1, 1890.

Quinquaud and Fournioux on Aristol.—According to these experimenters, a subcutaneous injection of aristol may be administered to guinea-pigs and dogs in the form of an oily solution in doses equivalent to the four-hundredth part of the animal's weight without producing toxic symptoms. It is partly eliminated by the urine in the form of an alkaline iodide and probably of thymol, this elimination requiring four or five days. No local inflammation was ever observed to result from the punctures.—*Lancet*, Oct. 11, 1890.

Desnos on Methylacetanilide or Exalgine.—According to the author exalgine has a special action on the medulla and cerebro-spinal system. It causes vertigo of various forms, accompanied sometimes by vomiting and even chills. Quite frequently general sweats, even profuse, occur, perhaps limited to the site of pain, for which the drug is given; also numbness extending to all the limbs, the tongue, or solely to the site of the neuralgia. Any dose may produce these nervous symptoms. Twelve grains may produce cyanosis, slight it is true. The author has observed it four times in forty cases. It is well tolerated by the digestive tract. It produces eruptions, somewhat like antipyrine. It lessens the amount of urine and the amount of sugar, if the urine contains any, and is readily eliminated by the kidneys. The author considers four grains a large average dose, but this should not be repeated under several hours.

Neuralgias of the face from a cold or of a rheumatic origin seem very amenable to

its use, while the pains of anæmia and syphilis although relieved are not cured without systemic treatment. The results in migraine seem doubtful. Intercostal and brachial neuralgias and ileo-lumbar pains from pelvic disease are relieved. The remedy has failed in sciatica. The author was able to relieve the pains of nephritic colic, of locomotor ataxia and those of dysmenorrhœa, and bring about a notable lessening of the tremor of paralysis agitans.

In rheumatism, particularly muscular, the author has met with remarkable success.—*La France Méd.*, Oct. 10, 1890.

Stewart (J.) on Exalgine as an Analgesic.—In all, the drug was given in ninety-five cases, with the result of a marked relief in fully seventy-four cases, or upwards of seventy-seven per cent. In the remaining twenty-one cases, the effect was slight or negative. The group of cases where relief was most marked were those of facial neuralgia. In all there were twenty-three cases of facial neuralgia, and in only three was there a negative effect or slight relief. In other forms of neuralgia it was given four times, with a good result in three of the four cases. It was administered in thirty-one cases of simple headache. In twenty cases relief was obtained, while in eleven the effect was practically negative. In one case of the lightning pains of tabes, marked relief followed its use. In four cases of acute pleurisy relief was marked. A similar result followed in four cases of acute rheumatism. In two cases of severe gastric pain the relief obtained was marked. In ten cases of abdominal pain from various causes, only six received a beneficial effect. The remaining sixteen cases comprised pains of a general and anomalous character, due to traumatism, etc. Relief followed in fourteen of these cases, while in only two was the result negative.

It will be noticed, from these observations, that the action of exalgine was most marked in cases of *pure* facial neuralgia, while it was least successful in headache. The cases of the latter where the drug was employed comprised headache from various causes. It is generally a difficult and frequently an almost impossible problem to ascertain, with any degree of exactitude, the cause of headache. This is the only excuse I have to offer for the vagueness of the term headache as here employed.

Slight nausea was complained of in one case, nausea and vomiting in four; in only two cases, however, was the vomiting directly traceable to the drug. One complained of numbness in the left arm, one of bad dreams, one of cold feet and legs. No cardiac depression was noticed, neither was there dyspnœa or cyanosis. Sweating was seen in some cases, but was never profuse.

It acts in half an hour, and reaches its maximum in an hour and a half.—*Montreal Med. Jour.*, April, 1890.

Gaudineau on Exalgine.—The author thinks the toxic power of the drug small, as he asserts that only in the proportion of four and one half parts of the drug to one hundred parts by weight of the animal does it kill. Under these circumstances the animal trembles, becomes insensible and convulsed, dying of asphyxia and collapse. Section of the dorsal cord does not prevent these movements in the hind extremities. The reflexes are exaggerated.

The poisoning has two stages; in the first, the motor nervous system is excited, while sensibility is diminished; in the second stage the poison acts on the blood and causes secondarily respiratory and cardiac troubles; the blood becomes dark, asphyxiated; oxyhemoglobin is reduced, forming methemoglobine, which colors the blood a dirty brown. The red globules are diminished in number. These changes prevent hematosis, and the animal dies asphyxiated with a subnormal temperature.

In the urine are found products resulting from the oxidation of anilides. Sugar is frequently present.

In healthy persons six to eight grains in divided doses produce few, if any, effects. Occasionally some uneasiness, ringing in the ears, slight confusion or intoxication, result, but the disturbance is transitory.

It is principally in congestive neuralgias that exalgine succeeds; in rheumatic and ataxic pains it is less useful.—*La France Méd.*, Oct. 8, 1889.

Macdonald (A. D.) on Exalgine.—First, it is almost of as much benefit to mankind to determine the minimum efficient dose of a drug, as it is to fix the maximum dose which may be given without poisoning or incommoding the patient. I take it that a one-grain dose every four hours is the standard of exalgine. Secondly, as the pain-subduing property of methyl-acetanilide is largely referable to its methyl molecule, and acetanilide itself possesses a much greater heat-suppressing

power, I suggest the following prescription in cases where both actions are desired: ℞ Antifebrin, grs. xxiv.; exalgine, grs. vj.; tr. card co., tr. limonis, āā 3 j.; aquam, ad ℥ iij. M. Sig. A tablespoonful to be taken every four hours. In a series of cases which I have treated within the past two months, and especially where the pain was limited to one temple, or "nail" like, I have found even one five-grain dose of phenacetine to give the most striking pain-subduing result.—*Brit. Med. Jour.*, March 8, 1890.

Pope (A. B.) on a Short Study of Exalgine.—The drug occurs in fine acicular or long tablet-like crystals. It is more soluble in hot than cold water, and very soluble in dilute alcohol. Chemically it is methyl-acetanilide with a formula $C_6H_5N\{^{CH_3}_{C_7H_5O}$, and is prepared by acting on sodium-acetanilide with iodide of methyl.

When given in doses of five grains, and repeated at intervals of four hours, no unpleasant effects have been noted, save in one case, where ringing in the ears and vertigo were complained of. In one of my patients, immediately after a dose of five grains had been taken, a feeling of faintness and impending death came on, but quickly subsided. There were no disagreeable symptoms subsequently in this patient when a similar dose was given.

Thus far no unpleasant effects have been noted upon the gastro-intestinal tract. It is antipyretic, but less powerful in this respect than antipyrine. It is analgesic, and said to be more powerful than antipyrine or phenacetine. Its primary action is upon sensibility, and secondarily upon temperature. It acts well in visceral neuralgias. As an anti-rheumatic remedy it possesses some power, but is not to be compared with the salicylates.

It lessens motor power in all animals, resembling in this respect formanilide and methyl-formanilide. Hypodermically administered, it produces local paralysis in the muscles into which it has been injected.

Similarly it arrests the heart. A small dose causes a slight rise of blood-pressure, but large doses diminish it. The urine is diminished in quantity, but otherwise not altered in health.

It has shown in several of my cases a distinct tendency to cause sleep. In one, after each dose, the pain was less severe, and the patient slept several hours. Whether it has a tendency to cause sleep, except indirectly through the relief of pain, I am unable to say.

It diminishes oxyhæmoglobin, and interferes with the oxygenation of the blood. It is antiseptic.

Experiments upon mammals show that its convulsive action, to be spoken of presently, is easily reduced by habit, and a study of several of the subjoined cases seems to lead to a similar conclusion with regard to its effect upon neuralgia in man.

When hypodermically administered to mammals, in a few minutes clonic epileptoid convulsions supervene, with profuse salivation. The convulsions are separated by periods, during which there are more or less cyanosis, dyspnœa, and agitation. We are informed that these convulsions, arrested by ether, are cerebral, but that the spinal cord is subjected to a certain degree of irritation. The temperature begins to fall quickly, and reaches its lowest (2° to 10°) in from three quarters of an hour to an hour. Death occurs from interference with oxygenation. The blood is of a dark prune-color, from the presence of methyl-hæmoglobin. The convulsions are produced by asphyxia, and in mammals a tolerance of the drug, especially in its power to bring them on, is readily established. In rats the fatal dose varies from one third to one half a grain to the one fifth of a pound of body weight; in the guinea-pig, one third of a grain for each one fifth of a pound of body weight. In the rabbit, nine grains were injected into a vein before death was produced. Four grains hypodermically caused very serious toxic symptoms in a cat.

The author then details six cases in which he has employed the drug. They are summarized as follows:

Case 1. — Occipito-orbital neuralgia, probably malarial. Relieved, not cured.

Case 2.—Trigeminal neuralgia. Not relieved.

Case 3.—Perineal neuralgia of traumatic origin. Relief.

Case 4. — Obstructive dysmenorrhœa. Partial relief.

Case 5.—Trigeminal neuralgia. Temporary relief.

Case 6.—Periodical headache. Partial relief.

These results are certainly not flattering.

The author concludes that the drug acts favorably in some cases where antipyrine

or phenacetine fail, or are contra-indicated. The initial dose should not exceed five grains, and care should be exercised in repeating the dose. It probably possesses some hypnotic power. It may cause symptoms resembling angina pectoris. It does not irritate the stomach, nor does it produce a rash or cyanosis.—*N. Y. Med. Jour.*, Feb. 22, 1890.

Sulphonal in Diabetes.—Dr. Casarelli, of Pisa, mentions the favorable action of sulphonal in diabetes. This drug diminishes the quantity of sugar in the urine, also reducing the polyuria and the thirst. These results were obtained by doses of from five to thirty grains per diem, but not to so marked a degree as with doses of forty-five grains continued for several days. The thirty-grain doses could be administered for some time without any ill effects; but although the forty-grain doses at first caused no disturbance, it was found that, when they were continued for any lengthened period, they caused giddiness and excessive sleepiness, which disappeared when the drug was discontinued. Sulphonal was used with good results in conjunction with both a mixed diet and a strictly meat diet; in the latter case a large quantity of sugar appeared in the urine as soon as the sulphonal was stopped. In the only case in which antipyrine had been previously used it was found to exert less influence than sulphonal. —*Lancet*, Nov. 1, 1890.

Toxic Effects from Sulphonal.—W. H. Gilbert, in the *Lancet*, October 25, 1890, says:

"Three cases of sulphonalism came under my observation and treatment during the past season. All three were middle-aged ladies of good social standing, who had been advised by their medical attendant to take about two grammes of sulphonal whenever they could not sleep. This had been going on for from three to five months, and the use of the drug had become a perfect mania—so much so that the absence of it caused symptoms similar to those experienced when overcoming the morphia habit. A feeling of intense dizziness, weakness of thought and memory, tottering gait as under the influence of alcohol, inability of writing straight (unsteady characters, and in an ascending line), loss of appetite, and general weakness caused the patients to seek medical aid, The complexion of these formerly healthy women had become somewhat sallow-looking, and the eyes rather dim and expressionless. After several weeks' treatment sulphonal could be dispensed with, and subsequently the patients were restored to their former good health."

Drs. M. and A. Jolles, of Vienna,[1] are undertaking an investigation into the physiological effects of sulphonal, some alarming cases having, it is said, occurred of death preceded by some peculiar physical signs, where patients have taken this drug for a considerable period. Most of the cases where serious effects have been observed have occurred in women. Suddenly the patient commences to pass reddish-brown urine containing hyaline, granular, and epithelial casts. This reddish coloring is believed to be due to methæmoglobin or to hæmatoporphyrin. The patient suffers at the same time from prostration, abdominal pain, vomiting paralyses of the extremities, bladder, and diaphragm, and soon dies. No rise of temperature seems to have occurred.

Molony (H. G.) on Exalgine.—The late epidemic of influenza left a very general heritage of neuralgia amongst my patients, and no drug that I tried for its relief was attended with such happy results as this. In one case of facial neuralgia, which had failed to yield to quinine, phosphorus, iron, or arsenic with anodynes, the administration of four grains of exalgine in divided doses was followed by instant and permanent relief. I commence with grain doses, repeated if necessary every four hours; and though I have sometimes had to double the dose before the analgesic effect was obtained, in no case did unpleasant symptoms follow its administration. I have found it, as a rule, useful in all forms of myalgia. I look on it as almost a specific in facial neuralgia occurring in anæmic neurotic persons.—*Brit. Med. Jour.*, Oct. 18, 1890.

Suttle (I. N.) on a Case of Antifebrin Habit.—The patient was a sufferer from necrosis of the tibia of the left leg, of sufficient gravity to confine him to his bed for more than eighteen months. The patient's former attendant and medical adviser during this long siege of suffering, pain, and gradual death, had employed some local disinfectant, washes, etc., and had ordered antifebrin in very large doses to

[1] *Hospital Gazette*, Oct. 25, 1890.

procure rest, repeated without hesitation in double quantity till the desired effect was produced. The first step in our treatment was amputation of the limb; and the chief difficulty in the after-treatment was to deny and prevent the use of antifebrin.

He had acquired such a liking for this drug that we could well pronounce it an antifebrin habit, equal almost in its pernicious influence to the baneful effects of opium. It had evidently produced a retrograde metamorphosis, a great destruction of colored blood-corpuscles, as could be seen by the blanched appearance of the patient's lips, tips of fingers, and extremities. It was observed that when given as the physician had directed (a spoonful of the pure drug, his wife said), and especially when it was repeated soon, his face became pallid, lips and fingers blue; but always, so far as the hypnotic effect was concerned, acting happily (?). During this long treatment it became so necessary an article that more than sixty ounces had been consumed. Other preparations, as bromides, hyoscyamus, and opium, when given to alleviate the great longing for antifebrin, were soon recognized, and the patient would call for his pet antifebrin.—*New Orleans Med. and Surg. Jour.*, June, 1890.

Hart (E.) on Ether-Drinking; its Prevalence and Results.—Ether began to be used as a stimulant and intoxicant in the place of alcohol about 1845. Observers differ in explaining the reason of this substitution. Some say it was one of the results of the teetotal movement, while a great impetus was given to its sale and consumption by removing the duty, in 1855–6, from alcohol to which one ninth of its bulk of wood naphtha (methylated spirit) had been added to render it unfit for drink, but still useful in the arts and manufactures.

The methylated ether, which is the variety consumed, is readily distilled from this adulterated alcohol.

This form of inebriety is most prevalent in the north of Ireland, in some districts being a very common habit. To give an idea of the prevalence of the vice, it is asserted that one dealer alone distributes over one ton of ether a year.

The usual quantity of ether taken at one time is two to four drachms, and this may be repeated many times daily. As a general thing, the mouth is rinsed out with water, the "neat" ether is tossed off, and a swallow of water taken. Some "old hands" drink it clear, without preparation.

The immediate and remote effects are interesting. The former are similar, but much more speedy than those of alcohol. The stages of excitement, mental confusion, loss of muscular control, and loss of consciousness, follow each other so quickly that they cannot be clearly separated from each other. It is only the "immoderate" ether drinkers who drink themselves into stupor; many are content not to go beyond the stage of exhilaration, when they become very talkative and laugh hysterically. The effect wears off almost as speedily as it comes on. What De Quincey said of the terrible attractions of alcohol is still more true of ether. The endeavor to renew the state of exaltation induced by the first dose drives the drinker to take more and more of the stimulant, till it becomes a tyrannical abuse, leading to effects precisely opposite to those first arrived at.

That ether is frequently drunk to the extent of inducing intoxication all my witnesses are agreed. Thus Dr. Graves, of Cookstown, says: "It is often drunk to intoxication at wakes and dances, especially in the more backward and mountainous districts. Its effects are very rapidly produced, and the stage of excitement very marked. Those under its influence will shout, dance, laugh, and act like maniacs, and if the dose has been heavy, may fall down writhing and foaming at the mouth. They recover generally soon, and feel low, weak, and depressed, and often then will renew the dose, for which they have generally a strong craving. A smaller dose produces exhilaration and a peculiar feeling of *lightness*, the person imagining he or she could jump up and fly."

The same close observer thus describes the symptoms often produced by ether-drinking: "Profuse salivation often follows the drinking of ether, and then usually rather violent eructations; the face becomes flushed, and may become livid if large quantities are taken; afterwards pallor, weakness, and burning pain at the epigastrium are generally present. Frenzy, maniacal excitement, and ultimately stupor, supervene when the dose is large, and taken within a short space of time."

Dr. J. W. Watson writes: "It is usually drunk for the purpose of producing intoxication, people drinking it and "treating"

each other as they do with whiskey in other parts of Ireland, or beer in England. The intoxication comes on quickly and passes off quickly. All ether-drinkers agree that it is a pleasurable form of intoxication, and others can see that it is a very violent form of intoxication. However, the most violent condition is produced when whiskey and ether are both taken." Dr. Watson and others say that ether-drinkers are very quarrelsome in their cups, the intoxication being decidedly of the "fighting" type.

With regard to the more remote effects of ether, there is not much to be said. Very little appears to be known by pathologists of any injurious effect it may have on the tissues. Dr. Richardson himself is fain to confess with some regret that there is not much to be said against ether-drinking from this point of view. There are no gross lesions like the shrinking and induration of brain and liver characteristic of alcohol; ether is a thief that steals away the brains without leaving any visible mark of his presence. I have made special inquiries as to its effect on the health, and so far as "moderate" drinkers are concerned, there does not seem to be any evidence that the habit produces any thing worse than chronic gastritis and dyspepsia. With regard to the worst cases, however, a careful observer writes: "In ether-drinkers who have long followed the habit I have seen general debility, great nervous prostration, accompanied by tremors (muscles of neck and forearm mainly affected), indigestion, irregular action of heart, subacute gastritis, a peculiar white, sallow complexion; and, in some cases (personally observed), a peculiar livid, cyanotic face."

Dr. Walter Bernard notes the following among the injurious effects on health which ether-drinking gives rise to: "Absence of subcutaneous fat, muscular wasting, feeble circulation, pale lemon- and brown-colored skin, reflexes exaggerated, especially knee-jerks." One terrible effect of ether-drinking is the profound degeneration of the moral character which it often induces; the victims fall into a kind of chronic hysterical condition, lose all self-respect, and, as in the case of nearly all who abuse narcotics, will lie and even steal to procure their favorite stimulant.

Touching the tendency of ether-drinking to produce insanity, my informants are divided in opinion. Dr. Hetherington, of the Londonderry District Asylum, writes: "I cannot connect cases of insanity directly with its use, though many of my patients have been addicted to the habit. The districts named have always had a large proportion of insane irrespective of ether-drinking." Dr. Walter Bernard, visiting and consulting physician to the same asylum, thinks that ether, while not *per se* a cause of insanity, calls into action any dormant tendency to insanity that may exist. My Cookstown authority has himself attended cases in which he considered "the insanity certainly to some extent dependent, both as an exciting and a predisposing cause, on the ether habit." Other correspondents deny that there is any connection, other than accidental, between ether-drinking and madness. The habit seems to lead to crime only through the violence and pugnacity which have already been alluded to as characteristic features of the first stage of ether intoxication.

With regard to the effect of ether-drinking on the duration of life, very little positive evidence is forthcoming. Dr. Walter Bernard says it tends to shorten life by interfering with nutrition and damaging the glandular system. Apart from this, it is obvious that the ether-drinker is a "bad life" from the insurance point of view, as he is exposed to many risks from which other people are free. He may at any time kill himself with an over-dose of his favorite drug. There have, I believe, been several sudden deaths in the ether-drinking district which have been attributed to this cause, and inquests have been held on them. I have tried to obtain details of one or two such cases, but have not been successful. The sudden deaths alluded to by more than one of my clerical correspondents, and utilized by them in the pulpit, were probably due to heart-disease. One peculiar danger to which it is alleged that ether-drinkers are exposed is that of setting themselves on fire in lighting a pipe, etc.—*Brit. Med. Jour.*, Oct. 18, 1890.

Von Klein (C. H.) on the Administration of Morphine by the Nostrils.—As a method of securing the rapid physiological effect of morphine without producing its disagreeable taste or the pain or danger of its hypodermic administration, the author advises snuffing up the requisite dose placed on the thumb, as is tobacco snuff. He says the physiological effects are quickly manifested, within fifteen seconds in some cases. His experience ex-

tends over one hundred cases. A smaller dose is required than by the mouth. Where the nasal cavities are encrusted with dry secretions they should be cleansed before snuffing up the remedy.—*Jour. Am. Med. Ass'n*, Oct. 25, 1890.

Kums on Injections of Sulphuric Ether in Neuralgia.—Referring to the favorable results accruing from the local injection of ether in neuralgias, the author says that he prefers the employment of Hoffmann's anodyne rather than pure ether, because it is more manageable, and is found in almost every household. The combination of ether and alcohol is more miscible with watery menstrua, and is more readily absorbed than ether alone.—*Ann. et Bull. de la Soc. de Méd. d'Anvers*, Aug., 1890.

Stocquart (A.) on Hypodermic Injections of Plain Water.—The author has employed this therapeutic procedure with success in five cases of neuralgia and muscular pain. He injects, with a hypodermic syringe, about 15 minims of cold water into the back of the neck. The injection generally causes some pain while the curative effect on the pain or spasm is generally prompt, and in the author's experience permanent.—*Arch. de Méd. et de Chir. Pratiques*, vol. iv., No. 9.

Harrington on Cocaine Poisoning.—I have many times injected two drachms of a 5-per-cent. solution of cocaine into the urethra for the purpose of passing sounds. On one occasion that amount was injected. In less than a minute the patient's arms and legs began to twitch and the face became contorted. I suppose that the attack was hysterical. The patient was a young delicate man of about twenty-five years. I endeavored to arrest the attack by shaking the patient and speaking sharply to him. It had no effect. Intense spasms, tonic and clonic by turns, came on. At one time the respiration ceased, and the face became very black. Artificial respiration was produced. The urethra and the bladder were immediately washed out. During this process there was an emission of semen. The pulse became very rapid and feeble. The eye became widely dilated. For five minutes the condition was very alarming. The attack gradually subsided, and the patient was able to go home in two or three hours. He stated that he had never suffered from epilepsy. The seizure resembled very closely an epileptic attack. The amount of cocaine which was absorbed must have been extremely small, and the attack may have been mere coincidence.—*Boston Med. and Surg. Jour.*, Nov. 9, 1890.

Martin (W.) on Veratrum Viride in Pneumonia.—The author concludes that veratrum viride, in the form of tincture, is the best remedy in pneumonia. Commencing with small doses and gradually increasing, it is a safe medicament. It should be given early, if possible in the first stage, though it is of use in the second stage. In subjects with broken-down constitutions, as inebriates, it should be given cautiously, as there is immediate danger from depression.—*Med. News*, Nov. 1, 1890.

Hughes (W. E.) on Lead Poisoning Treated by Phlebotomy.—The author has tried blood-letting in three cases. In one case one bleeding cured instantly and permanently a spasm of the right hand due to plumbism, and within a few days the abdominal symptoms and blue line on the gums disappeared. In another case the principal result of the bleeding was the restoration of power to the forearms. The abdominal symptoms were less relieved, still they yielded more rapidly to subsequent treatment than would be the case where bleeding had not been resorted to. A third case was discharged cured in a week.

The relief is probably due to two causes: first, to a relief of focal congestion in the cord or nerves; second, to a change in blood tension, facilitating the rapid elimination of the lead.—*University Med. Mag.*, Oct., 1890.

Hare (H. A.) on Podophyllin and Mercuric Chloride in Diarrhœa.—In instances where secretion is defective podophyllin in minute amounts is of value, and the indication for its employment is a history of constipation accompanied by the occasional passage of slightly colored or grayish stools, which has ended in a sudden reversal of symptoms, consisting in a watery diarrhœa of a more or less profuse type, containing particles of curdled milk or pieces of semi-digested food. These passages are often somewhat musty or mouldy in odor as the case progresses, and the entire attack is one in which the patient rapidly wastes, has persistent vomiting, and almost uncontrollable watery purging, which, if it be retarded briefly by powerful remedies, seems to renew its vigor through delay. Under these circumstances the fol-

lowing prescription is of service for a child of from sixteen months to two years :

℞. Resinæ podophylli . . . . gr. i.
Alcohol . . . . . f℥i. M.
SIG.—One drop in a teaspoonful of water every five hours.

In an older child two grains may be placed in the prescription instead of one. As soon as the passages begin to show slight evidences of intestinal secretion, as may be noted by the appearance of some tinge of yellow or brownish color, the physician will recognize that his remedy has not failed, and with the employment of proper diet can regard the child as on the way toward recovery. Generally, persistence in the use of this drug in the manner named for a day or two longer will bring the intestinal movements to a natural state without producing constipation, an extreme generally arrived at if astringents are employed.

The second form of diarrhœa is that in which the mercuric chloride is of value. It is characterized not by watery stools, but by mucous passages in which flakes or masses of mucus float in a little watery liquid, or are passed from the bowel alone or mixed with threads of blood. Sometimes particles of food are seen embedded in these masses of mucus, which by their toughness prevent the digestive juices from acting on the food, which they envelop like the gelatine coating of an old pill.

The following prescription is now of value :

℞. Hydrarg. chlor. corros. . . gr. ¼.
Aq. destillat. . . . . f℥ii. M.
SIG.—Teaspoonful every five hours.

—*University Med. Mag.*, Oct., 1890.

Cathelineau and Fournier (A.) on the Presence of Mercury in the Viscera of a Fœtus.—The mother was syphilitic and was subjected during pregnancy to mercurial treatment.

Mercury has been found in the urine of new-born children under similar circumstances before. In this case mercury was found in various organs in different amounts in the order named, the first-named organ containing the most: the liver, spleen, heart, kidneys, intestines, (meconium), lung, and brain.—*Annales de Dermatologie et de Syphiligraphie*, June 25, 1890.

Burlureaux on the Reaction of Saliva and Calomel in the Diagnosis of Iodoform Poisoning.—A soldier of twenty-two entered the hospital with a general scarlatiniform eruption, which commenced on the left arm three days after the application of an iodoform dressing to the same. There were some general symptoms, coated tongue, and prostration, but the temperature did not rise above 100° F.

Three days later desquamation took place, in thick sheets on the arm first affected, furfuraceous on the rest of the body. It seemed like scarlet fever in spite of the absence of angina and albuminuria and the slight fever. Iodoform poisoning was suspected. The patient complained of a taste of iodoform, and on putting a piece of silver in the mouth perceived a taste of garlic. By mingling a little saliva with a pinch of calomel the characteristic canary-yellow color appeared from the formation of the iodide of mercury. This sign persisted while the eruption lasted, and faded away gradually with desquamation.—*Annales de Dermatologie et de Syphiligraphie*, May 25, 1890.

Brooke (B.) and Hughes (W. E.) on Ergot in the Ordinary Sore-Throat of Phthisis.—The symptoms complained of by phthisical patients and relieved by ergot were as follows : Ordinary complaint of sore-throat, dryness of throat and mouth, difficult or painful deglutition, burning pain in the throat, and great thirst. From fifteen to forty minims of fluid extract of ergot were given three times a day.

Six cases are cited, and the relief, in all but one case, was unquestionable. The effect on the fauces, when much congestion was present, was very apparent.—*University Med. Mag.*, Oct., 1890.

A Successful Case of Transfusion.—It is always a pleasing duty to have to record examples of devotion to the welfare of their patients on the part of medical men ; and although but few such instances are ever recorded, they would, if published, form a long catalogue. Such an instance earned the just encomiums of the *Hull Examiner* in a recent number, where we find mention of the success attending the transfusion in a patient who had apparently been attacked by internal hemorrhage, the operator himself giving the blood. Although, very properly, our lay contemporary does not give the name of the operator who thus distinguished himself for his humanity and skill, there can be no objection to our stating that it was Mr. Robert Hagyard. We are also enabled to give

some details of the case. It was one of cancer of the breast, which had been removed ten days before by Mr. Hagyard. Whilst the wound was being dressed the patient was suddenly attacked by syncope. She became pallid and completely collapsed—a condition not to be accounted for by the fact that she was the subject of mitral disease. After the subcutaneous injections of brandy and ether, and the performance of artificial respiration, Mr. Hagyard decided to have recourse to transfusion. This was effected by means of Aveling's apparatus, the blood being taken from his right arm (he is left-handed), and injected directly into the patient's veins. It was calculated that more than a pint of blood was transfused, the operation being terminated by the operator becoming faint. The result was most satisfactory, for at the end of ten minutes the patient had completely recovered, and in a few days was able to leave the hospital. The cause of the collapse was thought to be internal hemorrhage, as on the following day the motions were observed to be blackened. There is no doubt that the patient owes her life to Mr. Hagyard's prompt and courageous act, which he had to perform with only the assistance of a nurse. It may be remembered that a similar instance of a surgeon resuscitating a woman suffering from puerperal hemorrhage by transfusing blood from his own arm was recorded a few years back from a Hampshire village; and we may recall the statement of Professor von Nussbaum (who, we regret to learn, is seriously ill), that he had given blood for this purpose no less than ten times. (*Vide Year-book of Treatment*, 1889, p. 116.)—*Lancet*, Nov. 1, 1890.

Green on the Chlorate of Potassium as a Preventive of Intra-Uterine Death.—The patient had borne two dead children in the eighth month; and finding herself again pregnant, and wishing for a living child, she sought advice. No evidence of syphilis could be found in either parent, and there was no other apparent cause for fœtal death; but it was arranged that the patient should be seen every few weeks during her pregnancy for observation and advice. During the early months treatment was directed to the alleviating of nausea, vomiting and constipation; a tonic pill of iron and quinine was given, and the patient was advised in matters of diet and personal hygiene.

Beginning at the end of the fourth month, chlorate of potash was prescribed in fifteen-grain doses three times a day. This drug was continued throughout the pregnancy, and the patient bore a large, healthy boy at full term. Whether or not the chlorate was the efficient cause in this happy result the reporter was unprepared to say. He used it on the recommendation of Prof. Simpson, of Edinburgh, and of others who had thought it efficacious in such cases in which intra-uterine death is thought to be due to non-specific disease of the placenta.—*Boston Med. and Surg. Four.*, Oct. 30, 1890.

SOME RECENT CONTRIBUTIONS TO THE STUDY OF SYPHILIS.

Fortuniadis on Chancre of the Eyelids.—In a Thése de Paris on the above subject the author states that of extra-genital chancres, those of the eyelids form about 3 %. The mode of contagion is hard to determine in all cases, being sometimes the finger, sometimes the mouth, sometimes the tongue. Physicians are infected by expulsion of saliva by the patient or by touching the eyes with infected fingers. The nurse's finger moistened with saliva and rubbed on infants' eyelids to separate or clean them infects some young children. In some locations the tongue is employed to remove foreign bodies from conjunctival sac and also in the treatment of trachoma. The latter vile procedure caused an epidemic of syphilis in a county in Russia; thirty-four persons (10 men and 24 women) being thus affected.

Chancre of the eyelids is generally situated on the free border and presents the aspect of an erosion or elevated vegetating papule. It is nearly always single, has a parchment or cartilaginous induration, is indolent and accompanied by slight if any pain. The lymphatic glands in the parotid, sub-maxillary, retro-maxillary, and cervical regions may be enlarged, while the pre-auricular ganglion is the most important.—*Ann. de Dermat. et de Syphiligraphie*, Oct. 25, 1890.

Marlow (F. W.) on Primary Chancre of the Conjunctiva.—The patient was a widow aged forty-nine. The left upper lid had been inflamed and swollen about one week; there had been sufficient

pain to disturb rest, and some discharge at the inner end; where the swelling was greatest, a deep circumscribed induration could be felt. The upper lid overlapped the lower and could not be everted. By lifting it slightly away from the eye the presence of chemosis was made out, and also the fact that the cornea and iris were normal in appearance. There was some flaky discharge. Lead lotion and hot fomentations were ordered.

Two days later the condition no better. The pre-auricular gland was enlarged. The possibility of its being a case of primary chancre was entertained. No ulceration could be made out, however, on the conjunctiva as far as it could be exposed.

Ten days later no improvement had taken place. Ulceration had now extended to the edge of the eyelid near the inner canthus, and a ragged ulcer could be seen on the palpebral conjunctiva by partial eversion of the lid. There was considerable pain; the pre-auricular gland was larger, and the glands under the left side of the jaw were swollen to the size of a small orange. The fauces were congested but no ulceration was seen. There was one doubtful spot on the nose but no general eruption.

The diagnosis of primary chancre was made, and confirmed before we left the house by finding that the patient's daughter was the mother of an illegitimate child, the subject of typical and severe inherited syphilis. It was small in size, wizen-faced, and covered from head to foot and down to its finger tips with papulo-squamous copper-colored eruption. The grandmother (the patient) had been taking almost entire charge of the child. It seemed most probable that infection had been produced by the fingers of the child coming into contact with the eye of the patient, although we could obtain no history of this fact.

Rapid improvement took place under the local application and internal administration of mercury.—*N. Y. Med. Jour.*, March 1, 1890.

Hallopeau on a Vegetating Form of Lingual Syphiloma, and its Diagnosis from Epithelioma.—In a patient suffering from deep syphilomata of the tongue, there grew, in spite of heroic and prolonged treatment, vegetating and indurated prominences, accompanied by adenopathies. The growth was thought to be epitheliomatous until examination of the tissue removed during life disproved the diagnosis.

The details of this observation teach: 1. That lingual syphilomata may persist and continue to proliferate in spite of energetic treatment. 2. That they may occupy simultaneously deep parts of the organ and parts subjacent to the mucous membrane. 3. That they may constitute indurating and vegetating tumors. 4. That they may take the form of papillomatous excrescences. 5. That they may be accompanied by glandular enlargements.

This lesion has been called lingual sclerosis, but is better designated as vegetating syphiloma.—*Annales de Dermatologie et de Syphiligraphie*, June 25, 1890.

Post (A.) on Some Considerations Concerning Syphilis and Marriage.—Before a syphilitic can be considered a suitable candidate for marriage—

The disease must have passed the period which comprises the usual secondary symptoms.

There must have been a well-marked period of entire freedom from symptoms.

The patient must have submitted to thorough treatment.

In discussing the danger in marriage, it must be said that a man may be considered to cease to be *directly* dangerous to his wife, while he is still in a condition to transmit the disease to his children; so that he may live in safety with a wife so long as there are no children.

My own opinion may be expressed as follows: In the very mildest cases two years is long enough to wait. The man has by that time ceased to be a source of direct danger to his wife; but even in those cases, I should prefer not to sanction the birth of children. For the severer cases a longer time ought to elapse. Possibly some of the worst cases ought not to marry at all. Treatment ought to have been thorough to sanction an early marriage. The medical adviser must be very slow to give more positive assurance of safety than the nature of the disease will permit. The actual responsibility of acting must rest with the interested party.—*Boston Med. and Surg. Jour.*, Dec. 19, 1889.

Syphilis and Marriage.—In an editorial article the *Provincial Medical Journal* (Nov. 1, 1890) calls attention to an interesting and recent case:

A young man consulted a very eminent specialist for syphilis. After a prolonged

course of treatment he, with the sanction of his medical adviser, married. A child was born, and to his great delight it showed no signs of the disease; the mother also remaining well. A second child was born, but to the grief of the father the second child was marked within a few weeks after birth with the unmistakable brand of the disease. The regrets of the father at ever marrying were poignant; yet he derived some consolation that he had done all in his power, and that he had the consent of the most noted syphilographers to his marriage.

Mauriac (C.) on Syphilis Communicated Four Years and Nine Months after Primary Infection.—The author was consulted in July, 1885, by a man concerning a primary syphilitic lesion. He had only slight secondary symptoms of a short duration, which recurred in constantly diminishing severity till the end of the second year. At this time, the disease seeming cured, the patient asked permission to marry. This demand was refused. From this time on he had occasional outbreaks of herpetiform eruption followed by slight erosions which did not seem to partake of the character of mucous plaques.

At the end of four years permission was given him to marry. He was still under treatment, and was tormented by the fixed idea that he would infect his wife.

In the spring of 1890 the wife was found to have a roseola, confluent mucous patches of the genitalia, and indurated tumors in the perineum, which were neither more nor less than hard chancres communicated to the woman from herpetiform erosions on the scrotum of the husband.

The author was satisfied as to the mode and source of contagion, which was extraordinary, inasmuch as the infection was from a subject of a mild case of syphilis more than four years after the initial lesion.—*Annales de Dermatologie et de Syphiligraphie*, July 25, 1890.

A Case of Reinfection with Syphilis.[1]—The case is recorded in the *Giornale delle Mal. Ven.*, of a woman, aged forty-six, who had contracted syphilis when a child from a schoolfellow. She suffered very severely at the time, and had the characteristic eruptions, tibial pains, sore throat, and subsequent abortions. Ten years later she had well-marked tertiary manifestations, which gained for her the soubriquet of *fistolosa* in her village. While she was still in the same deplorable condition she was reinfected by her husband, who had a chancre on the penis and was covered with a roseolar eruption. She came to the hospital, and was found to have a typical indurated chancre on the labium with corresponding glandular enlargement, and a confluent rose-colored papular eruption all over the body. She also complained of general malaise and pain in the shoulders and knees. These symptoms promptly yielded to treatment, and there would not seem to be any reason to doubt the accuracy of the diagnosis in both instances. Indeed, that exceptions should exist in the protection afforded by a prior attack of syphilis is only what a study of other specific diseases would lead one to expect.—*Med. Press*, Feb. 6, 1889.

The Differential Diagnosis of Vaccination Syphilis.—The *Deutsche med. Zeitung* of July 18, 1889, reproduces a summary of Professor Fournier's clinical lectures on this subject by Dr. P. Portalier. The lines of distinction between syphilitic and other appearances are drawn with equal clearness and elegance by the French syphilologist. I.—Differential diagnosis between vaccinal ulcers and primary chancre: The latter never develops before the fifteenth day after vaccination, the time required being mostly three weeks; twenty days after inoculation it is still in its earliest development. A "vaccination ulcer" is present, if ever, twelve or fifteen days after vaccination; after twenty days it is fully developed. The clinical differences are as follows: In the case of vaccination ulcer: (1) all the pustules are affected as a rule; (2) much inflammation and ulceration; (3) deeply-excavated ulcer; (4) much suppuration; (5) irregular margin as in soft chancre; (6) floor of ulcer uneven, suppurating; (7) inflammatory induration; (8) inflammatory, erysipelatous areola; (9) gland swelling none, or else inflammatory; (10) complications often present, sloughing, erysipelas, etc. Syphilitic ulcer: (1) is restricted to one or a few pustules—often these do not develop; (2) the inflammation is slight; (3) the loss of substance is superficial; (4) suppuration is scanty or absent, crusts form; (5) border not notched, slightly elevated, gradually lost in floor; (6) surface of floor smooth; (7) the "parchment" induration is specific,

[1] See MEDICAL ANALECTIC AND EPITOME, Oct., 1890, p. 469.

not merely inflammatory; (8) hardly any inflammatory areola; (9) gland swelling constant, indolent; (10) complications rare. II.—Differential diagnosis between vaccination rashes and secondary syphilitic eruptions: Under the former are comprised roseola vaccinalis, miliaria vacc., vaccina bullosa and hemorrhagica, also accidental rashes, rubeola, scarlatina, lichen, urticaria, etc. A true vaccinal rash (1) appears between the ninth and fifteenth day after vaccination; (2) absence of inoculation chancre; (3) eruption has not syphilitic characters; (4) is attended with fever; (5) is evanescent. A secondary syphilitic eruption (1) appears, at the earliest, nine or ten weeks after vaccination; (2) requires the pre-existence in every case of a specific ulcer at the site of vaccination, that is, to constitute the rash due to vaccination; (3) shows the characters of true specific eruptions; (4) is not attended with fever; (5) lasts a long time; (6) is accompanied, as a rule, with specific appearances on the mucous membranes. III.—Differential diagnosis of vaccination-syphilis from hereditary syphilis, which may show itself about the time of vaccination: Vaccination syphilis (1) begins with a local affection, chancre, and indolent bubo; (2) has a typical development in four stages—namely, incubation, chancre, second incubation, generalization (secondary rashes, etc.); (3) never appears earlier than the ninth or tenth week after vaccination. Hereditary syphilis (1) has no chancre, but begins with general phenomena; (2) has no typical development after vaccination; (3) is wholly independent of the latter as to time; (4) is attended by the habitus syphiliticus, or syphilitic bodily aspect; (5) other manifestations of hereditary lues may be present; (6) the history may indicate syphilis. The only point in the above admirable summary requiring correction is the statement that a secondary syphilitic rash is not attended by fever.—*Brit. Med. Jour.*, Nov. 16, 1890.

Haslund on the Causes and Conditions of Tertiary Symptoms in Syphilis.—The author's data are derived from a study of 5,636 patients treated for syphilis at the public hospital at Copenhagen during eight years (1882–1889). Of these cases 616 cases developed tertiary symptoms. Of these tertiary cases 189 had had no treatment before the appearance of tertiary symptoms; 345 had been insufficiently treated, and 82 had had what might be called proper treatment.

It would thus appear that of these tertiary syphilitics 86.75 per cent. had had insufficient or no treatment.

Of the 345 insufficiently treated 34 were alcoholic, 2 malarial, 4 suffering from chronic disease, 4 had contracted syphilis after the 55th year and showed precocious tertiary symptoms; in 13 the syphilis had been at first overlooked (of these 11 were women with extra-genital chancre). Some were treated by injection of soluble mercurials, some had an intolerance for mercury, some had left the tropics immediately after infection, some were extremely poor, and some were unfortunate in the conduct of their treatment.

The lesions involved the skin 343 times, the bones 105 times, the nervous system 163 times, mucous membranes 120 times, and the viscera 27 times.

The reason of these localizations is obscure, but the author queries whether a peculiar weakness, vulnerability, or previous diseased condition of certain tissues or organs may not invite the localization of the tertiary disease in them.—*Annales de Dermatologie et de Syphiligraphie*, Aug. and Sept., 1890.

REPORT ON OBSTETRICS AND DISEASES OF CHILDREN.

BY ELIZABETH STOW BROWN, M.D.

Rotch (T. M.) on the Management of Human Breast-Milk in Cases of Difficult Infantile Digestion. — The metabolic phenomena giving rise to the secretion of milk are marked and distinct, and have many analogies with the metabolism which we meet with in adipose tissue. We must look upon the mammary gland chiefly as a secretory organ, within, however, certain limits, for we, of course, know that at times foreign elements may be excreted from the gland. This opens up the question: When is the mammary gland most likely to have what we might call its normal secretory function interfered with, and when does it assume temporarily the function of an excretory organ? This apparently takes place both before the mammary gland has attained its equipoise, so to speak, as during the colostrum pe-

riod; and later, when any disturbing influences occur, affecting the mother's general condition. In the latter instance the milk is found returning to the colostrum period—that is, it may be assumed that the chemistry of that early period of lactation, which essentially represents a condition of lack of equipoise, is a condition of double function, partly secretory, partly excretory. The greater the excretory function of the gland becomes at any time in proportion to the secretory, the more abnormal will be the finished product; while the nearer the gland approaches to a purely secretory organ, the more perfect and normal the product. The chemistry of this equipoise and lack of equipoise of the mammary product appears to be closely connected with the albuminoid element. In this colostrum period, and probably in its analogous periods of sickness and emotion, the albumen is in excess proportionately to the casein, while as the equipoise of the function becomes more complete, the casein is increased proportionately to the albumen. Then, in the beginning of the lactation, when normal metabolism is interfered with, and as lactation draws to a close, we have analogous conditions, in which the mammary gland, instead of being a normal secretory organ, becomes abnormal and more or less an excretory organ. During these periods we should be careful not only to avoid giving drugs to the mother which might be eliminated by the milk, but should also closely watch the infant for signs of digestive disturbance, which may be at once corrected by withdrawing for a time the mother's breast.

The author strongly urges the practice of milk analysis. "Strange as it may seem, the unquestioned value of the milk analysis in clinical medicine is, as a rule, overlooked. Ten or twenty dollars spent for three or four analyses will, in a very large number of cases of difficult infantile digestion, render an obscure case clear, relieve the mind of the physician, and enable him to at once adopt the proper line of treatment. The milk analysis shows what the infant is taking into its stomach, and which part of the food is producing the unfavorable symptoms. The treatment is simply, knowing the error in one or more constituents of the food, to change them either to the normal average, or below it, until the digestive functions have recovered their equilibrium. In order to retain a fairly correct and at best only proximate knowledge of what the especial infant is taking into its stomach, when nursed at regular intervals, according to age, the proper method of obtaining the specimen to be analyzed should be carefully attended to. The specimen should be taken from the middle of the nursing.

The marked variations in human milk are almost always shown in the fat and albuminoids, and these constituents are the ones to be treated. A meat, or rather nitrogenous diet, increases the fat in the milk. Physiology teaches that ingestion of much fat tends rather to lessen the fat in the milk. The albuminoids are more difficult to deal with. They have a tendency to increase in poor, very bad, and very rich milk. The problem is almost always how to decrease them, and our knowledge of how to effect this reduction is very limited. Practically, however, when the woman is in good health, it is physical exercise that must be insisted on, preferably walking in the open air, and within the limits of fatigue.

Several interesting diagrams are inserted, showing analyses in various cases where the conditions were striking:

Diagram I. shows the influence of a luxurious life on a poorly fed but healthy wet-nurse.

Diagram II. shows the effect of the catamenia on human breast-milk.

Diagram VI. shows a bad milk, and one which was impossible to manage on account of the continual recurrence of the same cause—uncontrolled emotions.

Diagram VII. shows a milk possible to manage, because the mother, though excitable, was able and willing to control her emotions.

Diagram IX. shows a milk in which the albuminoids, which were disturbing the infant, could not be reduced until the mother was made to walk comfortably and thus without fatigue.—*Arch. of Ped.*, Nov., 1890.

Stowell (W. L.) on the Significance of High Temperature in Children.—The author summarizes his excellent article in the following statements:

The child's temperature is normally higher than that of the adult.

The temperature may be very high from apparently inadequate causes, usually nervous impressions or reflex disturbance.

The febrile diseases all have what may

be called their normal range of temperature, which does not indicate treatment unless excessive or out of its normal course.

Antipyretics are to be used with caution, lest, while they lessen fever, they weaken the heart, and so decrease the chances of favorable termination of the disease.

The fever may often be lessened indirectly by heart tonics, general tonics, and food.

The tendency of nutrition in childhood is towards growth and repair, not degeneration; hence careful nursing and feeding will do more towards a favorable result than converting the child into a drug analyzer.—*Arch. of Ped.*, Oct., 1890.

Playfair (John) on Croupous Pneumonia in Children.—This disease, in its pathological results and in some of its signs and symptoms, is the same affection as seen in the adult. In the child, however, it has some interesting peculiarities which the author proceeds to point out. He presents (in tabular form) a series of thirty cases of croupous pneumonia in children, all of which were treated in the writer's ward in the Children's Hospital in Edinburgh.

As to age: nineteen of the cases occurred between eighteen months and six years; eleven between seven and twelve years. The sexes were about equally represented.

The right lung was affected in sixteen of the cases, in eleven it was the left, and in three both lungs were attacked. As to the region of lung affected, in twenty-one it was the base, and in eight the apex. In one case the whole lung was consolidated by the time of admission.

In the two fatal cases, though in both the whole lung ultimately became affected, the disease began in each at the base.

As to nervous symptoms, eleven are stated to have suffered from headache, delirium, and herpes labialis; but in only four of these was the upper lobe the seat of the disease.

The author had investigated the previous diseases from which these children had suffered. Thirteen had had measles, eight whooping-cough, while other diseases occurred very infrequently.

The twenty-seven cases that recovered had an average duration of fifteen days.

Crises occurred in twenty-one cases, and in thirteen of these it took place on the fifth or sixth day. Of the nine cases where crises did not occur, two ended fatally.

A practical point connected with the fever of croupous pneumonia is that, when the fall of temperature takes place, it is usually rapid and decided, and is frequently accompanied by great prostration and cardiac weakness.

Seven cases occurred in winter, ten in spring, and two in autumn.—*Edin. Med. Jour.*, Oct., 1890.

Garrigues (H. J.) on Ear Presentation.—Although much diversity of opinion exists as to Naegele's obliquity in normal cases, it is certain that, in abnormal cases, the head may be bent so much toward one of the shoulders above the line of the pelvis that the ear presents. The head may either be approached at the anterior or the posterior shoulder. In the first case the sagittal suture is found running transversely from side to side, near, close up to, or above the anterior pelvic wall; the posterior parietal bone and the posterior ear present themselves at the brim of the pelvis. In the second case, the sagittal suture runs in a similar direction near the promontory of the sacrum, and the anterior parietal bone and ear present themselves. These presentations are called the *right and left anterior and posterior parietal presentation;* or, since the ear is easily felt, the *anterior and posterior ear presentations, right or left.* They are probably of rare occurrence. Dr. Garrigues has seen but the one he reports. As a rule, in these cases the pelvis is narrow, but, even with a normal pelvis, an anterior ear presentation may be caused by anteversion of the uterus and pendulous abdomen. Under other circumstances the causes are unknown.

In most cases the prognosis is favorable, as the head either changes its relations to the body under the influence of labor pains, or is manually replaced by the accoucheur. But if the abnormal attitude continues after the waters have broken, the situation is a serious one, as the head cannot pass through the pelvis when so placed. If feasible, podalic version and extraction are indicated; if not, the head must be diminished by means of perforation and evacuation.

Dr. Garrigues gives the history of a case in which he successfully corrected the presentation by putting the patient in Sims' position and exerting pressure.

The author would here call attention to the posterior side fontanelle, which is, he thinks, unduly neglected in the text-books.

This fontanelle is by no means rarely felt, and gives exactly the same sensation to the examining finger as the upper posterior fontanelle, three sutures meeting to form either. At the superior posterior fontanelle we have the sagittal and the two branches of the lambdoid; and at the posterior side fontanelle it is the lambdoid joining the masto-parietal and the masto-occipital.

It is particularly desirable that the accoucheur should know the existence of ear presentations, on account of the possibility of the examining finger coming in contact with an eye, as in the above case, a circumstance that may give rise to irreparable injury to that delicate organ.—*Am. Jour. of Med. Sciences*, June, 1890.

Playfair (W. S.) on Management of Lingering Labors.—The author considers only those cases not attributable to mechanical obstruction, but simply due to uterine inertia. Dr. Playfair said that, in his opinion, versed on his own experience and corroborated by the views entertained by the authorities of the leading maternity hospitals of Great Britain, the use of ergot prior to the expulsion of the placenta was practically obsolete. He relies more upon position and pressure over the abdomen. He considers chloral hydrate the most valuable drug to be used up to the time the head presses upon the perineum, when he uses chloroform.—*Brit. Med. Jour.*, Sept. 27, 1890.

Hartill (John T.) on the Complications of Labor in Two Thousand Consecutive Pregnancies.—This report on the complications of two thousand consecutive labors includes all the complications of at least four thousand five hundred confinements in a manufacturing town in the Black Country, largely occupied by artisans, whose wives and daughters work in factories.

In this series of cases, those labors are considered the most dangerous when the placenta wholly or partly presents. Of complete placenta prævia, there were six cases; of incomplete, eight. Of breech presentations, forty-three; of presentations of the lower extremity, thirteen of foot, two of foot and funis, one right foot and left knee, one of knee, one of knee and funis—in all eighteen cases of podalic presentations.

The author performed version thirty-seven times. Of face presentations there were fifteen.

Forceps cases were sixty-two by short forceps, seventy by medium, and thirty-two by long forceps. Of these thirty-two, no fewer than fourteen of the patients had well-marked pelvic deformity. There were four cases of craniotomy, arising out of failure to deliver by forceps, all with excellent result to the mother.

Premature labor was induced in six cases; puerperal convulsions were present in four. In twenty-two cases there was adherent placenta.

In the two thousand cases thirteen deaths occurred from all causes, of which eight or nine only were the direct result of parturition.—*Brit. Med. Jour.*, Sept. 27, 1890.

REPORT ON DISEASES OF THE NOSE AND THROAT.

BY CHARLES H. KNIGHT, M.D.

Hay Fever.—The two chief theories of the pathology of hay fever, one of which regards it as a pure neurosis, with periodical exacerbations such as characterize all nervous phenomena, the other holding it to be a reflex neurosis dependent upon a lesion or a morbid condition of the intranasal structures, have been combined in a practical way by Sir Andrew Clark, whose views are adopted by Dr. F. W. Hinkel. According to this observer we have (1) a neurotic temperament, inherited or acquired, as evidenced by the fact that the disease is confined largely to the white race, whose nervous systems have been overdeveloped; (2) a local condition of irritability or disease. The great local factor is a nasal abnormality causing pressure, it may be a deflected septum, a polyp, mucous membrane hypertrophy or merely general turgescence; and (3) an external exciting cause. The latter is not single or circumscribed. The emanations of flowers, various forms of vegetation, dust, sunshine, and probably chemical and electrical states of the atmosphere, play a part.

Dr. F. H. Potter devotes a paper to considering the treatment of these cases. He observes that no case is known to have been cured by constitutional measures alone. On the other hand local treatment alone may give a brilliant result, but it is apt to be only temporary. Active interference should not be attempted during an

attack. Palliative measures include attention to hygienic precautions as regards bathing, clothing, diet, etc., the local are of bland nasal washes, and the application of oil to the irritated surface. The nares may be further protected by wearing a small piece of sponge in each nostril. Cocaine, in not stronger than 4 % solution, may be used, but not too frequently for fear of its toxic effects. Internally small doses of atropia ($\frac{1}{100}$ gr.) and muriate of morphia ($\frac{1}{3}$ gr.) alleviate the symptoms and will sometimes prevent an attack.

In treating the local condition removal of obstructive lesions is advisable. When operative treatment is not required to relieve obstruction or proves ineffective we must resort to measures tending to overcome the hyperæsthesia of the mucous membrane. The paper closes with a reference to the various internal remedies which have been employed, and to the application of the cold douche to the spinal column which has found favor with some.—*Buffalo Med. and Surg. Jour.*, Sept., 1890.

Epistaxis.—In the *Med. Record.* N. Y., Oct. 4, 1890, Dr. W. W. Parker describes a very simple and effective method of controlling nosebleed, which he uses to the exclusion of Bellocq's cannula and other methods. Fifteen or more threads of lint, or coarse spool cotton, about four inches long, are tied together at their middle, folded upon each other, and pushed into the nasal fossa, so that the loose ends are at the anterior naris. The nostril may be plugged in front if need be. The method is comparatively painless, the plug gives no discomfort and may easily be withdrawn in twenty-four to forty-eight hours.

Dr. F. H. Potter, in the *Jour. of the Am. Med. Ass'n.*, Sept. 27, 1890, calls attention to a class of cases in which the hemorrhage occurs from extreme tenuity of the mucous membrane associated with septal deformity. There is no erosion: the tissues are simply unable to withstand the blood pressure. The treatment recommended is cauterization with chromic acid, repeated, if necessary, four or five times. The bleeding points are frequently found along the sutural lines, at the union of the triangular cartilage with the vomer and the perpendicular plate of the ethmoid.

(In the course of a discussion of a paper by Dr. Carl Seiler, entitled "The Importance of Preliminary Treatment of the Nasal Mucous Membrane before Resorting to Operations," read at the last meeting of the Am. Med. Assn., the use of chromic acid was deprecated by Dr. E. F. Ingals, and Dr. Seiler said that it should never be used in the nasal cavity, because the acid is well known to be a solvent of bone and cartilage, and there is great difficulty in limiting its action.—*Jour. of Laryngol. and Rhinol.*, Aug., 1890.)

Stewart (W. R. H.) on Adenoid Growths in the Naso-Pharynx, Commonly Called Post-Nasal Growths.—The author recognizes but two methods of handling these growths: first, destruction with the galvano-cautery or chemical caustics; and second, excision. The former is unsatisfactory, and is demanded only in the case of bleeders; the latter should be done under chloroform with Gottstein's ring-knife and the finger-nail, or with Woakes' modification of Löwenberg's forceps. The ring-knife does more execution, but there is apt to be more bleeding, and the fragments cut off are likely to be swallowed. The position preferred is the recumbent one, the patient being flat on the back. No complications have arisen from blood finding its way into the air-passages, except in one case, that of a delicate girl, who was threatened with pneumonia. The operation should be done at the patient's house, if possible, in order to avoid the danger of taking cold, which might induce an otitis. The after-treatment consists of syringing the nostrils twice daily with a warm boracic solution. The author has met with but one case of serious hemorrhage, and in that the bleeding was controlled by thoroughly plugging the naso-pharynx with antiseptic wool.

The paper closes with the recital of an extraordinary case, which occurred at one of the London hospitals. After removal of a few growths there was a sudden gush of blood, with immediate death as the result. "The operation was performed with Woakes' modified Löwenberg's forceps; the posterior wall of the naso-pharynx had been cleared, and the operator was proceeding to remove a growth from the right side, when the fatal gush of venous blood took place. Unfortunately no post-mortem examination was allowed, but the supposition was that an enlarged vein of the pharyngeal plexus was torn down."

This is how the case was related to me. We know that the veins of this plexus are at times very large, but this hardly explains the almost instantaneous death. It, however, directs attention to a most serious danger in these operations, and is a point scored in favor of the ring-knife—*Lancet*, Sept. 20, 1890.

Luc and Dubief on Adenoid Tumors of the Nasal Pharynx at Different Ages.—The ages of four cases whose histories are given are 4½ years, 25 years, 25 years, and 54 years. From a study of these cases the authors conclude as follows:

1. Retrogression of adenoids of the naso-pharynx is an established fact.

2. It is not proved that the retrogression occurs at maturity

3. On the contrary, the microscope shows the existence, in a certain number of young adults, of these tumors absolutely identical with those occurring in childhood.

4. They may be for the first time a cause of auditory trouble not until the thirtieth year.

5. This process of retrogression takes place more slowly in later life, depending upon the constitution and mode of life of the individual, and is characterized by the sclerous changes typical of advancing years.—*Arch. de laryngol., de rhinol.*, etc., Aug., 1890.

Marcy (H. O.) on Cure of Cleft Palate by a Double-Flap Operation and Closure with the Double Tendon Suture.—I commenced the operation by the introduction of a tracheotomy tube. With careful washing and irrigation the nasal and oral passages were rendered aseptic, using freely a sublimate solution of strength 1–1000. After the introduction of the mouth-gag, and packing the pharynx with an aseptic sponge, the soft palate was seized upon either side, the edges slightly refreshed with scissors, and split laterally to the depth of about one third of an inch. The posterior flaps thus formed were carefully joined by a very fine over-and-over tendon suture. A somewhat larger suture, commencing at the angle at the base of the division of the flap, was carried laterally from side to side, through the centre of the soft palate, a little beyond the line of lateral division. This line of sutures extended quite to the uvula. The approximation of the sides of the wound necessarily everted the edges, and by so much increased the fresh surfaces brought in contact, while at the same time it completely buried the line of sutures. The everted edges, presenting in the roof of the mouth, were then carefully joined by a very fine continuous tendon suture. Two double-looped stitches, taken as far away from the central line as possible, were then introduced, in order to prevent any lateral strain upon the central wound. The mouth and nose were closed, and only rarely required to be cleansed of mucus during the four subsequent days; after cleansing they were dusted with iodoform by means of the iodoform blower Respiration went on comfortably through the tracheal tube. A large injection of weak beef tea, given once in six hours, served the purpose of food and drink. The wound remained non-infected, and repair ensued as in aseptic wounds in other parts of the body, with the exception of the tip of the uvula, where a small slough formed from over-constriction of the suture.—*Jour. of the Am. Med. Ass'n*, Oct. 25, 1890.

Gleitsmann (J. W.) on a Case of Primary Tuberculosis of the Pharynx.—This history is one of unusual interest, and the successful result, which now seems to be assured, sixteen months having elapsed since the last ulceration cicatrized, and the patient being in much improved general condition, is doubtless due to the thoroughness and persistence with which treatment was carried out. The treatment is admitted to have been quite painful, but was borne with great fortitude. In addition to lactic acid the galvano-cautery was used at times. —*N. Y. Med. Jour.*, Oct. 11, 1890.

Luc on the Curability of Laryngeal Tuberculosis by Surgical Treatment.—The author divides tubercular lesions into two classes, those which are accessible and those which are situated beyond surgical intervention. The number of cases included in the latter group decreases with improvement in surgical technique, and among diseases recently transferred to the former we find tubercular disease of the larynx. It must be admitted, however, that the surgical treatment of tubercular laryngitis has not attained in the hands of others the brilliant results claimed by its promoters, Heryng, Krause, and Schmidt. The author has perseveringly used the lactic-acid treatment after curetting for

three years, having been encouraged in his efforts by the results in a case of naso-pharyngeal tuberculosis. This case was originally published in the *Arch. de laryngologie*, 1889, p. 19., and the patient is still living, one year after the operation, has gained largely in weight under systematic super-alimentation and strict hygiene, and exhibits complete cicatrization of all the parts primarily affected. None of his laryngeal cases has given an equally fortunate result.

In determining the availability of the method in a given case, four points have to be considered: (1) the general condition, (2) the state of the lungs and of other organs, (3) the precise site of the laryngeal lesion, and (4) the personal character and social condition of the patient.

It is contra-indicated if the general condition is bad, or if cachexia be present. The presence of pulmonary disease certainly impairs the prospect of cure, but it must not be forgotten that death is far more terrible from laryngeal than from pulmonary tuberculosis, so that we should not hesitate to undertake treatment of the larynx, even in case of coexistence of extensive pulmonary disease, provided the laryngeal lesions are limited and so placed that but few sittings will be required, and that without inflicting excessive suffering and fatigue.

The question of situation of the lesion is very important. Certain localities, as the epiglottis, on account of its mobility, and deep infiltrations in the neighborhood of the crico-arytenoid joint, are unfavorable. The most favorable are the ventricular bands and the pre-arytenoid region, points of resistance being here given to the curette. Excessive reflex excitability, or unfavorable anatomical conformation, may furnish insurmountable obstacles.

Finally, the method is contra-indicated if the patient is not endowed with considerable courage and perseverance, since, in spite of the advantages offered by cocaine, the operation is painful, and there is a certain amount of shock to the nervous system involved. Again, our patient should be in a position to avail himself of all the benefits to be derived from change of climate, healthful occupation, nutritious diet, and good hygiene. While taking a very conservative view of this method of treatment, the author disclaims any desire to discourage further experiment, merely wishing to warn against its indiscriminate application. Selected cases only should be used, lest the method meet with unmerited discredit.—*Arch. de laryngol., de rhinol.*, etc., Aug., 1890.

Symonds (C. J.) on the Treatment of Laryngeal Disease in Tuberculosis.—In a paper read at the recent Berlin Congress the author reviews the methods of treatment now in vogue. He recognizes as objects of the treatment (1) relief of cough and dysphagia, thus improving nutrition by enabling patients to swallow with comfort; (2) diminution of liability to pulmonary affection; (3) productive of more rapid recovery in cases disposed to spontaneous cure. The cases suitable for surgical treatment are those in which there are no signs of pulmonary disease, those in which there is severe dysphagia and cough, with pulmonary disease not rapidly progressing, and those in which the pulmonary disease is early or chronic. The tubercular tumor is more amenable to treatment than the ulcer, and lastly the infiltration and œdema.

Three propositions are offered: 1. That tubercular disease of the larynx should be treated on the same lines as elsewhere—that is, by destroying it by an irritant, or by removing it by erasion or curettement. 2. That at present lactic acid is our best application. 3. That endo-laryngeal methods are sufficient to remove and treat the disease in the majority of cases.—*Jour. of Laryngol. and Rhinol.*, Oct., 1890.

Gouguenheim and Glover on the Indurative and Proliferative Forms of Tubercular Laryngitis.—An abstract cannot do justice to this very careful paper, which deals with the pathological anatomy, the diagnosis, and the therapeutics of laryngeal tuberculosis. The authors are advocates of surgical treatment, and give interesting details of several cases.—*Jour. of Laryngol. and Rhinol.*, Sept. and Oct., 1890.

Tymowski on the Treatment of Ulcerations of the Larynx with Resorcin.—For several years the author has been using resorcin as an application to laryngeal ulcerations in tubercular subjects, in whom for any reason the method of Heryng could not be employed. In superficial ulceration an 80-per-cent. solution is used. In deeper and more extensive ulceration 120-per-cent. solutions give as good results as lactic acid without pain.

Good hygienic conditions, appropriate diet, exclusively liquid, and absolute rest of the voice are insisted upon.—*Rev. de laryngol., d'otol.*, etc., Sept. 15, 1890.

THE SURGICAL TREATMENT OF PERITONITIS.

ABSTRACTS BY GERTRUDE B. KELLY, M.D.

Wheeler (Leonard) on Laparotomy for Tubercular Peritonitis.—Indications for operation :—

1. Abundant ascites.
2. Absence or small amount of solid masses.
3. Disease primary in the peritoneum, though the mere presence of tuberculosis elsewhere does not forbid operation. Some cases have apparently recovered entirely when there was slight coexisting disease of the lung, both peritoneum and lung becoming healthy.
4. Encysted disease—that is, serous or purulent pockets.
5. Intestinal obstruction.

In the last two operation is imperative. Contraindications :—

1. Absence of ascites.
2. Abundant masses or strands.
3. Secondary to advanced general tuberculosis.
4. Intestinal ulcers.

The last two forbid operation.

Method of operating : The abdomen should be cleaned out as well as possible by flushing with hot water and sponging, separating meanwhile any adhesions which can be broken without injury to the viscera. No antiseptic and no drainage tube, unless for some special reason, as, for instance, hemorrhage. Tapping should not be practised. It may do harm, and cannot do as much good as laparotomy.

In all, one hundred and twenty-six cases of tubercular peritonitis have been reported as operated upon. Assuming that survival one year after operation entitles a case to rank as successful, I find, among one hundred and twenty-six cases, thirty-seven such, or thirty per cent. Fifteen per cent. of the cases are reported cured.—*Boston Med. and Surg. Jour.*, Sept. 11, 1890.

Lydston (G. F.) on Early Operative Interference in Acute Peritonitis, with Especial Reference to the So-Called Idiopathic Peritonitis in Children.—Conclusions :—

1. I do not believe in the existence of acute idiopathic primary peritonitis.
2. The majority of cases of so-called idiopathic peritonitis in children will be found, upon inquiry, to be traumatic.
3. Slight injuries of the abdominal contents are relatively more dangerous in children than in adults.
4. Acute peritonitis in children, while apparently idiopathic, is often secondary to perityphlitic inflammation, which runs a rapid course, and extends to the general peritoneum without the intervention of appreciable local changes.
5. The profound prostration and cardiac inhibition characteristic of peritonitis are, in a great measure, due to (1) tension of the peritoneum, produced by inflammatory products, with a consequent reflex inhibition of the heart, and (2) mechanical interference with the heart's action.
6. Surgical interference is indicated in all severe cases of general peritonitis and in cases of localized suppurative inflammation, or in cases of perityphlitic origin, whether due to foreign bodies or not.
7. There is every indication present for operation, and none against it. The operation is almost invariably palliative, if not curative.
8. Operation in no sense impairs the chances of recovery. On the contrary, it enhances them to a great degree.
9. No case should be allowed to die without operation, unless already *in articulo mortis*.
10. It is not necessary to make a large incision, except in cases in which perityphlitic abscess is known to exist, which is rarely the case in children. If perityphlitic abscess exists, and is recognized before operation, the incision should be made at the most favorable point, which, in the majority of cases, is the typical line for ligation of the common iliac, as pointed out by Murphy and Lee. In by far the majority of cases in children, a simple median exploratory incision, with flushing of the abdominal cavity, is sufficient.—*Jour. Am. Med. Ass'n.*, June 28, 1890.

Davis (W. E. B.) on the Treatment of Local and General Peritonitis.—The following points have been pretty well settled by pathological study :—

1. Simple peritonitis, when caused by a sufficient quantity of a chemical irritant, will produce death by the extent of the inflammation.

2. Simple peritonitis may terminate in septic peritonitis by producing a weakened condition of the walls of the intestines, which permit the passage of septic germs from the intestinal canal into the peritoneal cavity.

3. While pathological germs in a small quantity may be absorbed by the healthy peritoneum without producing a peritonitis, the same quantity combined with a chemical irritant may produce a violent inflammation —the irritant having prevented the absorption of the germs and caused the exudation of a nutrient fluid for their multiplication.

4. Large quantities of septic fluids and microbes always produce suppurative peritonitis, yet a small quantity of either may be absorbed and destroyed, unless the peritoneum has been weakened by antecedent pathological changes.

5. A septic fluid may gravitate into dependent parts of the peritoneum, and become shut up either by plastic inflammation or by a coil of intestine, and there be prevented from producing diffuse peritonitis, but, after a time, rupture of the sac may occur, and diffuse peritonitis be produced.

6. The germs of septic peritonitis will be found in the kidneys and other organs of the body, and in greater quantities according to the extent and duration of the inflammation.

7. The condition of the peritoneum and the nature and quantity of the septic product will determine the rapidity of the inflammation, which usually ends in from forty-eight hours to six days, but death may be produced from shock in a few hours. Tubercular inflammation is always slow in its progress.

From a consideration of the foregoing principles, the following indications for treatment must be arrived at :—

1. Promote absorption of the inflammatory products of simple peritonitis as rapidly as possible, and thus relieve the inflammation and prevent the possibility of septic peritonitis.

2. In the early stage of peritonitis, whether simple or septic, where the cause cannot be determined, hasten the absorption of inflammatory products, etc., with purgatives.

3. When medical treatment fails to give relief, septic fluids should be removed by operative procedure.

4. In localized peritonitis—with circumscribed pus formation—the pus should be removed and the abscess cavity drained.

5. In acute septic peritonitis operative procedure must be adopted early or there will be no chance of recovery offered by the operation, as the inflammation will become more extensive the longer it continues, and, too, there will be so great a quantity of septic germs absorbed into the system that death will result from toxæmia, even though the local inflammation should be remedied by a late operation.

It has been demonstrated that, in the large majority of cases, peritonitis is a symptom of some well recognized lesion of the abdominal or pelvic viscera, and that the only rational treatment must be based upon this conception of the disease. Peritonitis is not a "disease distinct," as taught by Bichart, and upon which teaching the treatment of Alonzo Clark gained such great popularity. The "opium splint" is irrational, for it not only locks up the products of inflammation, but, as shown by Wylie, Johnson, Baldy, and others, and by my own experience, subjects the patient to one of the greatest dangers of the disease, viz., obstruction of the bowels from adhesion.

In cases of perforation of the bowels, opium is indicated to relieve pain and shock, and to prevent peristalsis and further escape of the intestinal contents into the peritoneal cavity. Again, morphine hypodermically may be used with benefit when there is persistent and uncontrollable vomiting, but at the same time calomel in small and frequently repeated doses may be dropped on the tongue, and the bowels induced to act. There are many cases in which it is absolutely necessary to give a hypodermic injection for pain, but this should never be given in such doses as recommended by the advocates of the opium treatment, and should not be administered at all unless the patient's condition is being made more grave by the shock provoked from pain. Of course many cases of simple peritonitis will get well without treatment, and opium may relieve the pain, but it always subjects the patient to the danger of septic inflammation, and to obstruction of the bowel from adhesions, and in many cases destroys every vestige of chance for the patient, as the diagnosis will thus be obscured and an operation not resorted to in time.

The first two indications for treatment are best met by free purgation, as taught by Tait and others, and the majority of

those who have accepted this plan select the magnesium salts as they produce very large, watery stools. When the stomach rejects salts, calomel may be used. In a case of beginning local peritonitis I prescribe one tablespoonful of Epsom or Rochelle salts, and teaspoonful doses to be repeated every hour till the bowels act six or seven times. In the beginning of a general peritonitis, when the bowels are tympanitic, I begin by giving a tablespoonful in a half glass of water, and direct that the dose be repeated every hour till the patient is freely purged. This treatment is especially indicated in the threatened peritonitis we so often meet after laparotomies. I have seen the symptoms of a beginning peritonitis, which occurred on the second or third day after these operations, promptly cut short by the administration of a few concentrated doses of salts, or of calomel in from one- to three-grain doses repeated hourly.

The purgative treatment of peritonitis frequently proves a very valuable diagnostic measure. If it does not succeed, we know that an operation is generally indicated. I have seen this treatment succeed a number of times when I was confident that a laparotomy would be necessary.—*Cin. Med. Jour.*, July, 1890.

REPORT ON INTESTINAL SURGERY.

BY CHAS. B. KELSEY, M.D.

Briggs (W.) on Extra-Abdominal Surgery and the Use of Animal Membranes as Splices or Grafts.—The author has been experimenting in abdominal surgery on two lines, both of which are valuable. The first is the maintenance of the wounded intestine outside the abdominal cavity during the preliminary stage of reparation; and the second is in the more constant use of an animal membrane as a covering of the wounded portion of the intestine and the sutures.

In enterectomy, for example, the membrane may be taken from any of the serous surfaces of a recently slaughtered animal. Bullock, sheep, and hog membranes have been used with equally good results The membrane is taken from a four per-cent. solution of carbolic acid in which it has been resting and applied to the intestine so as to cover the sutured ends, and stitched to the mesentery by a few light sutures of the finest catgut. In the course of three or four hours a remarkable change will be seen. The membrane, which, when applied to the intestine fitted loosely and irregularly, will be found lying smoothly and tautly stretched over the surface with which it has been in contact, and so closely and firmly united to it at every point as to form practically a part of the intestinal wall. Its physical appearance has also undergone a change; from the flabby, dead look which it had when first applied, it has assumed a living appearance, and its edges have been smoothly bevelled, so that, except for the difference in color, it would be almost impossible to discover the line of juncture.

It seems that this use of animal membranes as a covering for fresh wounds is well known to hunters, trappers, and those employed in slaughter-houses.

For keeping the piece of sutured gut outside the abdominal cavity until primary union by plastic exudation has occurred (four or five hours), the author has invented a grooved metal shield or ring, fitting accurately into the abdominal incision. The coil of gut is pulled through this ring, fastened by pins through the mesentery, and covered by absorbent cotton-batting well covered with pure glycerine to prevent its adhering. After four or five hours all danger of extravasation will have passed, the shield of membrane will have become firmly attached, the ring may be removed, and the abdominal incision closed.—*St. Louis Med. and Surg. Jour.*, July, 1890.

Robinson (F. B.) on the Rawhide Plate for Intestinal Anastomosis.—The rawhide plate is made by shaving the hair from the green hide of an ox. Then cut the hide into strips an inch wide and two inches and a half long. Perforate the plate by a diamond-shaped aperture (half an inch by three quarters of an inch). Then apply four to six sutures to the plate, armed with four to six needles, and it is ready for use. The plate can be used either dried or green. If the hair is shaved from the green hide and then the hide is dried, it thickens and stiffens it so that almost any kind of plates suitable to any part of the alimentary canal can be obtained. The features of these rawhide plates are: they are eminently suitable for the operation of intestinal anastomosis;

they are easily prepared, quite accessible, and very convenient; they are suitably absorbable and can be well adapted to the character and quality of the intestinal tract.

The author also has experimented extensively with grafts of animal membranes and strongly advocates their use. The surface of the graft and the surface to which it is applied should be scarified with a needle point and held in position by a few fine sutures. The grafts should be large enough to completely cover the whole ground. If the wound is extensive, more than one graft may be applied. Grafts two by four inches live well and attain remarkable vitality. The grafts are best obtained from the omentum and may be used in two ways. One is to apply the omentum (the edge or any part) around the parts operated on, fix it in position with sutures, and leave it unsevered from the omentum, not cutting it away from its original attachments. The objection to raise against this method is that it will make an arch under which intestines will slide to and fro, and may become herniated. This may happen, but in one hundred and fifty post-mortems by the author it never has happened—the autopsies being made from one to eighty days after the operation. This method of graft application is very certain in its healing, and many times the author has found distinct fæcal fistulæ, which were arrested by the thickened graft. In these cases the graft is absolutely the means of saving life.

The other method of using peritoneal or omental grafts is to completely sever them from some part of the peritoneum or omentum, and then apply them over the part and fix them by a few sutures. The author has successfully applied grafts three inches by five from the omentum without any sign of loss of vitality. If omental grafts are used they should be taken from the edge (cut or torn), and not from the centre or interior. This was done a few times, tearing an omental graft out of the interior of the omentum, leaving a hole varying from two inches by four inches to three inches by six inches in this membrane. In one case of gastro-enterostomy an aperture was torn, and at the autopsy, two weeks after, six or eight feet of small intestine were found prolapsed through the hole in the omentum. The edges of the aperture had become rounded and thickened, and might strangulate the prolapsed intestine at any moment from mechanical or pathological causes.—*N. Y. Med. Jour.*, Oct. 18, 1890.

The same author more recently has presented another plate to the profession. It consists of the combination of a ring of cat-gut (rawhide or sheep-skin) fastened to a plate made of two pieces of rubber. The two pieces of rubber are stitched together at each end with a stitch of cat-gut, and the ring is sutured to the sides of the rubber plate with two cat-gut sutures. The whole plate and ring are thus held together with cat-gut only. Six holes are cut in the rubber plate, through which the six needle-armed sutures of the ring are inserted. A triangular piece is cut out of each approximating edge of the segments composing the plate, so as to make a perforation for fæcal circulation.

The suitability of this plate becomes very apparent when one can determine beforehand the time the plate will remain in contact by the quantity and quality of the material composing the ring. The plate does not yield its approximating power until it entirely breaks down by the dissolution of the ring of cat-gut, sheep-skin, or rawhide. It produces uniform, even, equable pressure in all directions. No jutting prominences nor uneven projections are exposed on the plate to cause sloughing of the parts, gangrene of the gut-wall, or to produce fæcal fistulæ.—*North Am. Pract.*, Oct. 1, 1890.

McGraw (T. A.) on Resection of the Intestine.—After detailing a successful case of resection with end-to-end apposition without rings or plates, the author enters into a very suggestive discussion of Senn's methods. In his own case he excised about three inches of the bowel, cutting it obliquely to its longitudinal axis and removing more of its free than of its attached surfaces. The ends of the gut were then brought together with a double row of sutures of fine silk, one for the mucous membrane and one for the muscular and serous coats, and the seam tested by forcing the contents of the bowel through the repaired portion. The union was sufficiently tight to prevent leakage, and the bowel was returned into the abdomen.

As compared with lateral anastomosis, the end-to-end suture appears to the author to be preferable for the following reasons: The direct union of the divided ends makes the most direct and unobstructed passage possible. The union by anasto-

mosis makes a canal which has a decided bend with an inevitable, even though slight, obstruction at the point of union. Our experience as regards the ultimate results of such unions is too limited to enable us to form any correct idea of the dangers which may arise from such persistent abnormal relations. The author does not say that any such dangers would arise—simply that we do not know as yet whether they would or not. If, in making an intestinal anastomosis, a portion of the bowel is excised, and the ends turned in and sewed up, the subsequent union by anastomosis will leave two blind pouches similar to the cæcum, one on each side of the orifice of communication. Now, if trouble arises sometimes in the cæcum from fæcal accumulation and impaction, how much more likely would it be to arise from abnormal pouches, which would not be so favorably situated for evacuating their contents as the cæcum.

If in making an intestinal anastomosis the bowel were not excised, there would be left a portion of the gut of greater or less length, which would be left practically without function, and at the same time be temporarily or permanently obstructed at some point in its continuity. What might be the final fate after months or years of such a degraded bowel, no man is in position to say, nor can we as yet reckon the chances of the occurrence of acute obstructions in the loop of intestine thus abnormally united and dragged out of place. The vermicular motion of such a gut must of necessity be interfered with. So also the free motion of the intestine within the abdominal cavity, a motion very necessary to intestinal health, as it permits the bowel, by changing its position, to adapt itself to the ever-changing condition of its contents.

The author also calls attention, on theoretical grounds, to what has been found the case in actual practice—the cicatricial stenosis of the anastomotic opening.

As regards the operation of intestinal anastomosis, the one great superiority claimed for it over other modes of uniting divided intestine is the rapidity with which it may be executed. The author has made a large number of experiments on dogs in order to determine the relative rapidity with which these various modes of operating may be carried out, and has found, taking one case with another, that the operation of intestinal anastomosis, with division of the gut and inversion of the ends, takes, from the moment when the gut is divided to the moment when the operation on the gut is completed, about twenty minutes; that of intestinal anastomosis, without previous division of the gut, about fifteen minutes; that of end-to-end suture, with double row of stitches, about twenty-five minutes, if he uses interrupted sutures, and about eighteen minutes with continuous sutures.

The mesentery is first sutured at its junction with the bowel, where there is a triangular raw surface of considerable size. Then, beginning at one side of the mesentery, a continuous suture is run around the edge of the mucous membrane, carrying first toward the mesentery. It is possible to sew the mucous membrane together from within the gut until a little more than half its circumference has been joined; after that, the needle must be carried around the internal mucous membrane from without. When the whole mucous membrane has been joined together with inturned edges by a continuous suture, then, beginning at the mesentery, the serous membrane is united by a continuous Lembert suture until the mesentery is reached on the opposite side. In this way we have a double row of sutures around the gut, one uniting the mucous and the other the serous surfaces. The outer row, it is true, does not completely encircle the gut, as it is broken at the insertion of the mesentery, but the suture of the cut mesentery, with its broad, raw surface, practically completes the row, as its surfaces will unite as quickly and firmly as the serous surfaces themselves. —*The Physician and Surgeon*, June, 1890.

Senn (N.) on the Different Varieties of Apposition Plates.—The author says, after having tried all kinds of material, organic and inorganic, absorbable and inabsorbable, for making apposition plates, he has finally settled on decalcified bone as the most suitable material. Experience has taught that it is unsafe to use material for plates which, when exposed to the fluids of the alimentary canal, will imbibe a sufficient amount of fluids to increase to two or three times in thickness, as such increase in the thickness of the plates may cause a sufficient degree of pressure to cause gangrene of the parts included between them. This happened in at least two of his gastro-enterostomies. The different kinds of rings devised by Abbe,

Matas, and Brokaw, as substitutes for the bone plates, lack some of the most important advantages possessed by the plates. Catgut is a material which, when brought in contact with the alkaline secretions of the intestinal canal, becomes, in a few hours, so soft and macerated that it cannot be relied on as a support. All ring supports bring into apposition only a small area of serous surfaces, and the pressure is not equally distributed. Davis' catgut mats are superior to the catgut rings, but the material of which they are composed is so highly hygroscopic that, when acted upon by the intestinal contents, they swell up rapidly and become as soft as rags in a few hours. He immersed one of the plates of Dr. Davis in a warm solution of common salt, and in three hours it had increased to three times its former thickness, and had become so limpid that, in the same condition in the intestinal canal, it would furnish little or no support in maintaining uninterrupted apposition. The same objection applies to the catgut rings and catgut mats as in the dried bone plates, that, when used in the dry state, they increase rapidly in thickness from the imbibition of fluids, and, as the sutures are unyielding, the pressure thus produced may result in gangrene.

Decalcified bone plates, kept moist in an antiseptic solution, do not increase in thickness by the imbibition of fluids when used in the stomach or intestines, and they serve as an efficient mechanical support in bringing together and maintaining accurate coaptation of large serous surfaces which it is intended to unite in establishing an anastomosis. The plate can be relied upon in maintaining equable pressure for at least three or four days, which is the time required in obtaining a sufficiently firm union by cell proliferation from the apposed serous surfaces.—*Jour. Am. Med. Ass'n.*, June 14, 1890.

REPORT ON ORTHOPÆDIC SURGERY.

BY JOHN RIDLON, M.D.

Gibney (V. P.) on Operative Procedures in the Bone Diseases of Childhood.—The writer of this essay is convinced that the orthopædic surgeon should be familiar with operations on bones that enter into the formation of the joint. He is also convinced that the success of these operations depends largely upon the mechanical protection given to the limb or joint during the reparative process, and even long subsequent to the reparative process.—*N. Y. Med. Jour.*, Aug. 16, 1890.

Judson (A. B.). A Criticism of Willett's Operation for Talipes Calcaneus.—By means of two sticks, representing the tibia and the foot, a spring-balance, and a bag of shot, the writer demonstrates that the tension upon the tendo-Achilles in standing on tiptoe is three times the amount of the superincumbent weight. Hence, he argues, we should not expect that tissues (of the calf of the leg) so weak as to have already stretched, to stand the strain without again giving away when a portion of the tendon has been resected.—*N. Y. Med. Jour.*, Aug. 23, 1890.

Wirt (W. E.) on a Theoretical and Practical Demonstration of the Action and Tension of the Tendo-Achilles in Supporting the Body on Tiptoe.—This paper, though published prior to Dr. Judson's paper above noticed, was read subsequently to it and was intended as an answer. By a most profound mathematical calculation the writer demonstrates that, instead of the foot and ankle being a simple lever of the second class, thus following its simple laws, it partakes more of the quality of a mechanism in which there is considerable loss of power, due to the force acting at a disadvantage, *i. e.*, the force acting in one direction being opposed by its own reaction as transmitted in a slightly different plane, plus the weight of the body.

Therefore the tension on the tendon is 1½ times the weight of the body when the foot is just leaving the horizontal position, and rapidly diminishes as the foot is raised into extreme tiptoe, being only ½ the weight of the body in the latter position, when the deep muscles are considered.—*Med. Record*, June 28, 1890.

Whitman (R.) on the Treatment of Persistent Abduction of the Foot.—The condition referred to is that which is commonly known as chronic sprain.

Abduction of the foot is the position of weakness; adduction, that of strength and activity.

In other words, the usefulness of the foot depends upon the preponderance of power of the adductor muscles. When this is lost, weakness and pain ensue. If this

proposition is accepted, the treatment becomes simple:

Discover what movements of the foot are restricted, with the apparent causes.

Then a persistent endeavor to overcome such restriction—

1. By forcible reposition to break up adhesions and to overstretch the contracted muscles and ligaments.

2. A long-continued massage intelligently applied by the surgeon.

3. A re-education of the patient as to the proper positions and movements of the foot. —*N. Y. Med. Jour.*, Oct. 11, 1890.

Ashmead (A. S.) on the Non-Existence of Rachitis in Japan.—All foreign observers agree in stating that the disease rachitis is exceedingly rare, if not wholly unknown, in the Japanese islands. A majority of them claim that it is absent. During a nineteen months' children's clinical service in Tokio the writer was not privileged to meet with a single case of the disease, none presenting itself for treatment. Through his intercourse with native colleagues he found out that no such disease had ever been brought to their notice.

If rachitis, as the disease is called with us, is but comparatively rare in Japan, the reason for it is extremely interesting, in connection with the fact of the syphilitic and tuberculous infection of its people.

The children are nursed late, even until they can run about and talk; they are fed upon fish after the first year; the mothers consume fish and fish-oils abundantly at all times; and this, taken with our present treatment of rickets by phosphorus and cod-liver oil, leads the writer to suggest that it behooves us to learn the lesson which Japan thus teaches us, adding to this sound treatment by the phosporized cod-liver oil a general and more constant lactation, checking that prevailing tendency to wean prematurely, and adopting a fish diet for both mother and child.—*Med. Record*, Oct. 11, 1890.

Lane (W. A.) on the Deformities Which Develop in Young Life.—To treat the simple acquired deformities, it is obvious that we should attempt (*a*) to improve the nutrition and vigor of the individual; (*b*) to prevent his assuming attitudes of rest, especially that one which is particularly responsible for his deformity; (*c*) to cause him to adopt habitually attitudes of activity; (*d*) to make him perform such exercises as shall improve the condition of his muscular and articular system both of the body generally as well as the affected part in particular; (*e*) in suitable conditions to apply such a mechanical arrangement as will tend to reverse the amounts of pressure which have before been transmitted through the several portions of the epiphyseal lines, and in this manner to modify their rates of bone-formation, and so cause the bone to resume its normal form. These means can be applied with advantage in most of the acquired deformities, but not in all, for obvious reasons, as, for instance, lateral curvature; (*f*) to avoid as much as possible the use of instruments which interfere with the full development of muscles, etc.; (*g*) to make him rest for sufficient periods of time in suitable postures; (*h*) in suitable cases, as in advanced flat-foot, to remove the deformity, and to place and retain the part as much as possible in a position of activity for a considerable period of time, by means of a suitable apparatus.

In the rachitic subject similar methods are adopted to influence the rate of growth at the epiphyseal line, and every means must be made use of to remove the changes in the form of the softened diaphyses, which constitute such a marked feature in the disease.—*Lancet*, Aug. 9, 1890.

Borck (E.) on the Treatment of Hip-Disease.—In the second stage it is advised to make subcutaneous division of the capsule as follows: A small incision is made into the skin over and posterior to the trochanter major; with a strong probe or a dull grooved director I explore my way, separating the tissues down to the capsule; a small knife with a long neck, such as a tenotome, is then inserted alongside of the director down into the capsule, separating it freely; the fluid escapes into the surrounding tissue and is then absorbed. There is very little hemorrhage. The patient then enjoys rest. The parts are put in complete fixation with a pair of wire breeches, or similar apparatus that will answer the purpose. Nature, assisted by hygienic treatment, completes the work; the patient recovers within two or three months. According to my experience, nothing can be accomplished with the so-called extension and counter-extension.—*Kansas City Med. Index*, Sept., 1890.

McCurdy (S. L.) on Hip-Joint Disease with Cases.—A new brace is described, composed of a double system of

bars extending from a belt around the pelvis on the outside and a perineal crutch upon the internal side of the thigh down to a stirrup fastened to the bottom of a neatly fitting shoe. These double systems of bars are so arranged that they slide upon each other and are held together by a collar from the proximal ends of the bars. Elastic straps are applied with the aim to give elastic traction.—*Cleveland Med. Gazette*, Aug., 1890.

Ridlon (J.) on a Report of Sixty-two Cases of Hip Disease, Observed in the Practice of Hugh Owen Thomas.—The writer reports on 62 cases of hip disease, which he had personally examined and measured. Four were new cases, and were recorded simply to show the condition of cases when presenting for treatment. The average duration of limp in these cases before treatment was commenced was a little over ten months. The average duration of treatment was not computed, as only a few were cured cases, and as many had been under treatment but a very short time.

Of the 58 cases that had been under treatment for a longer or shorter time, 24 had shortening from one quarter to two and one half inches; 24 had adduction; 5 had abduction; 3 had inward rotation; 2 had outward rotation; and 1 had in-knee. At some time during the course of their disease 24 had one or more abscesses. In 31 cases motion was not tested lest it should harm the patient. In 27 it was tested; 12 had no motion; 10 had some motion; 2 had motion to ninety degrees; and 3 had normal motion. In all the cases the general health was good.

In conclusion the following suggestions were offered: In very many of the cases where the joints had been only partially immobilized (by the use of the short splint), and where there had been no protection from the superincumbent weight and the concussion of walking, the result was imperfect; but in those cases where the long splint had been worn until a cure had been effected, and where the horizontal position had been maintained until all pain and muscular spasm had subsided, and where crutches and a high patten had been employed, a cure had been effected without flexion or other deformity than the shortening due to actual bone erosion and arrested growth. Motion at the joint, in the cured cases, was found in a large proportion of cases as compared with the results of other plans of treatment.—*Med. Record*, Oct. 4, 1890.

McCurdy (S. L.) on the Mechanical Treatment of Synovitis.—The writer serves up in original packages the chaff which Henry G. Davis winnowed from the wheat thirty-five years ago, and which Milton Josiah Roberts attempted to foist on the public some years since. He says:

I desire to make the sweeping statement that elastic extension, properly used in any case of synovitis of the human anatomy, will cure it, even in the state of suppuration, with little anchylosis or deformity.

The claims that may be made for elastic extension may be tabulated as follows:

1. Intra-articular pressure should be removed, thus putting the inflamed surface at rest.

2. Reflex muscular spasms should be overcome and voluntary muscular power restored as much as possible.

3. The functional activity of joints should not be interfered with more than is absolutely necessary.

4. The movements of the diseased articulation should at all times be under the control of the surgeon.

5. The general nutrition of the patient and the local nutrition of the involved joint should be maintained at the highest possible standing, for the purpose of general growth and repair of the diseased tissues.

6. Sufficient linear support should be furnished the patient to counterbalance the loss of supporting power on the part of the affected member, thus permitting the patient to walk about.

7. Automatic or self-acting mechanisms should be utilized as far as possible.

8. The use of unyielding, rigid, or cumbersome appliances, should not be resorted to.—*Pittsburgh Med. Review*, Aug., 1890.

Taylor (H. L.) on a Ready Method of Counter-Extension at Knee.—The author said that the knee is frequently the seat of surgical inflammation, but is favorably situated for diagnosis and treatment. Properly applied counter-extension, *i.e.*, in the lines of the degree of flexion instinctively assumed by the patient, with fixation, usually affords prompt relief to the suffering and provides conditions favorable to the nutrition of the joint and the subsidence of the inflammation. Fixation alone, or simple traction, do not give the same results.

The basis of efficient counter-extension is the adhesive plasters applied to each side of the leg above and below the knee, and ending in webbing at their ends near the ankle and near the pelvis. To give a firm grasp of the leg I use a pair, or two pairs, of strips of narrow rubber plaster, sewed to the side-plasters near where the webbing is fastened, and wound spirally around the leg toward the knee above and below, that is, I use four three-tailed or five-tailed plasters. As an improvised splint we may use two long, stiff strips of wood, like laths or window-curtain sticks, cut nearly the length of the leg, and having buckles fastened near each end. They are to be bandaged to the sides of the leg in such a manner that the knee will not be straightened when the webbing is reflected over the ends of the sticks and drawn into the buckles. If there is much flexion, sticks with the proper angle of flexion can be readily prepared; or, the plasters having been applied as described, a plaster-of-Paris case, with firm edges, in which buckles have been imbedded at each side near the ends, may be used as the basis for counter-extension. Whatever the dressing employed it is of the utmost importance that no prying or twisting force be exerted upon the knee. These simple methods have been used with satisfaction as a temporary dressing in several cases.—*Med. Record*, Oct. 16, 1890.

Lovett (R. W.) on Lateral Deviation of the Spine as a Diagnostic Symptom in Pott's Disease.—Some thirty unselected cases of Pott's disease were measured. The apparatus by which the measurements were taken was a very simple one, consisting of an elastic steel pelvic band, which was buckled about the pelvis at the level of the anterior superior spines, and to the middle of this at the back just over the sacrum, was attached by a pivot a movable steel upright which could be placed in the line of the deviated column, and its divergence from the perpendicular noted on a graduated arc attached to the pelvic band. Rotation of the spinal column was measured by a horizontal arm revolving on this upright, the two ends of which were placed against the ribs, and the deviation of the plane of the chest from that of the pelvis read on another graduated arc.

In all of these thirty cases, with one exception, the deviation was enough to be easily measured by the instrument, reading in degrees. In the one case mentioned, although asymmetry was perceptible, it was so slight that the instrument did not record it. In no case was a lateral deviation of more than eight degrees from the perpendicular found, and that was so much of a distortion that it seemed as if the children would lose their balance and topple over sideways in walking. In only four cases of the thirty was there as much divergence as eight degrees, and even this must be an accidentally large proportion of such severe instances of the deviation.

A divergence of five or six degrees was decidedly noticeable, so much so that it gave decided difficulty in fitting braces on account of the inequality of the two sides when the child stood up. Cases which were progressing well showed only a divergence of two or three degrees, which would not be noticed except on careful inspection, but which is enough to be distinctly perceptible when the child is regarded from in front without his apparatus.

To sum up, it is first necessary to insist upon lateral curvature of the spine as an exceedingly common, if not a uniform, symptom of Pott's disease in the lumbar and dorsal region. This deviation is generally accompanied by a certain amount of rotation, which does not follow the same rule as in scoliosis.

The lateral deviation is for the most part a symptom of muscular irritation reflex to joint inflammation, and belongs to the same class as the malpositions of other diseased joints. It yields readily to treatment, and is most rapidly reduced by rest in bed and spinal extension, though the ordinary treatment of Pott's disease is generally sufficient to overcome the lateral deformity if efficiently carried out.

Finally, I would call your attention to the importance of extending and verifying these observations, in the hope of adding, in lateral deviation, a new and simple diagnostic symptom by which the early detection of Pott's disease may be rendered less difficult.—*Boston Med. and Surg. Jour.*, Oct. 9, 1890.

Lovett (R. W.) on the Treatment of Cold Abscesses without Drainage; with Report of Cases.—The objection to the operative treatment of cold abscesses (an objection which pertains equally to the expectant method) lies in the failure of the wound to close, and in

the persistence of sinuses at the seat of operation for months, and perhaps years. In forty-three cases of abscess of the hip operated on at the Children's Hospital, between 1884 and 1888, only one case is recorded as having healed within six months of operation, and about half of the sinuses healed within periods varying from one to two years, the rest remaining open almost indefinitely. These cases were all thoroughly cleaned out after a free incision, and were either packed with gauze, or, more commonly, drainage-tubes were inserted, and an antiseptic dressing applied. In the writer's personal experience the site of the drainage-tube was almost always the site of a sinus which persisted for a varying period of time.

It is hardly necessary to point out the great discomfort that results from a sinus left at the seat of operation, and the decided advantage in avoiding it, if possible, by legitimate means.

To avoid, if possible, the sinus which the drainage-tube seemed always to leave after the rest of the wound was healed, the writer removed, in several instances, the tubes at the end of twenty-four to thirty-six hours after operation, but after the rest of the wound had closed, the hole left by the tube was still open to granulate, and generally continued for a long time as a sinus. The amount of discharge from abscesses which had been properly cleaned out was at first very small, and in many cases no pus appeared so long as an antiseptic dressing was continued on the wound; nevertheless, the sinuses continued to discharge serum, and when an open dressing was applied it turned to pus. The experiment was then tried of cleaning out the abscesses with especial care, and dressing them without the use of drainage-tubes, allowing the dressing to stay in place for two or three weeks. Four cases are then reported in detail, and the author concludes:

It would seem, therefore, that in many cases of cold abscess connected with bone disease, where from the nature of the case it is not possible to obliterate the whole abscess cavity or to exterminate the focus of disease, it is worth while to attempt to obtain primary union by careful cleansing and drying of the wound, and by its closure either by suture or by light compression, and by the application of a permanent dressing.—*Boston Med. and Surg. Four.*, Sept. 18, 1890.

Bull (T. M.) on the Prescription of Exercise.—The general rules in prescribing for sedentary men are as follows:

1. Consider the man and prescribe something which can be carried out. Don't tell a clerk on eight dollars a week to go horseback-riding at two dollars an hour, or try to have a two-hundred-and-fifty-pound man ride a bicycle, because these means are those you enjoy. Don't try to force the inland resident to row, or the one who dwells at the seaside to climb mountains. All are good enough in their places and in proper cases, but as a prescription they are not so likely to be carried out as something more suitable.

2. Whatever you prescribe for patients, have them begin gradually. The novelty of a thing will be apt to make a man overwork at first, in which case he is sure to be disgusted the next day and not likely to try it again if he thinks he will have the same experience. I have known a piano player so used up by his first few minutes with a pair of Indian clubs that he never touched them again. So always give the caution and tell them that if soreness or stiffness follows, it will quickly wear away, and soon no amount of exertion will make them sore.

3. Whenever you prescribe exercise of any kind, be sure you are acquainted with the state of the heart, lungs, and arteries of the patient. Also see if he is ruptured or liable to be.—*N. Y. Med. Four.*, Aug. 9, 1890.

Little (E. M.) on Causes of Rotation in the Vertebral Column in Scoliosis.—The causes of vertebral rotation are not yet known. The author has endeavored to find out when and how rotation of a healthy vertebral column is noticeable. His first researches were carried on among living beings. When in a vertical position voluntary flexion is made there seems to occur a slight rotation of the vertebral column dependent solely upon the contraction of the muscles. This contraction is entirely absent in either active or passive flexions of the subject in the recumbent—that is to say, in the horizontal position.

In the cadaver, when the viscera of the chest and abdomen have been removed, flexion produces no rotation whatever, even when all the ligaments of the bodies of the vertebræ and the intervertebral cartilages are separated one after another.

Trial made on a detached portion of the dorsal spinal column gave, under double pressure, a simple incurvation.

Then on fixing the twelfth dorsal vertebra and exerting anew a double pressure, there resulted a double curve, similar to an S. In that portion of the spine next the chest the curve exceeded a radius of seven centimetres. The transverse processes touched, but there was no trace of rotation on fixing the spinous processes and making pressure. A slight rotation made by the hands caused a twisting of the vertebræ to a maximum of 25 degrees. After having separated all the ligaments, and having made a rotary pressure, the vertebral column divides into several segments, until the articular ligaments arrest the movements.

The author is of the opinion that for twisting of the vertebræ to take place there must be a certain predisposition, a weakness in the tonicity of the ligaments, and a debility of the bones. The twisting itself is occasioned by the action of the muscles, the convex muscles being most concerned in it.—*Ann. d'Orthopédie*, Oct. 15, 1890.

OCCASIONAL REPORT ON INSANITY AND NERVOUS DISEASES.

BY FREDERICK PETERSON, M.D.

James (P.) on a Case of Lightning-Stroke with Recovery.—P. J. F., age forty-three, was in his hut December 14, 1889, in a thunder-storm. He was discovered speechless and partially unconscious eighteen hours afterward, and brought before Dr. James on the 16th of December. The hair and whiskers on the right side of his head was scorched, and the skin was erythematous. A thin red line ran down the sternum and abdomen to the pubes, where the hair was burnt. The skin afterward desquamated along this line and on the right side of the face and nose. The hair of both legs was singed, and the skin of the heels burnt. His mind was clear, but he recollected nothing of what had occurred. His speech was almost unintelligible, and his mouth was full of viscid mucus. The plantar reflexes were exaggerated. The cremasteric, abdominal, and patellar reflexes were normal. There was no clonus. No paresis or paralysis of limbs. No deviation of the tongue. Paresis of soft palate and difficult deglutition. There was retention of urine, and anal sphincter only partially controllable. Co-ordination of legs impossible. Pulse full and only 44. Respiration, 11–12. Temperature normal. Pupils normal. Some photophobia, slight drooping of left eyelid, and some diplopia. Paresis of one internal rectus. Hearing, smell, taste, normal.

Day by day he improved. Pulse and respiration became normal. After a week, however, had pains all over, and was restless. Jan. 3d passed urine voluntarily for first time, but catheter necessary for a time occasionally. Jan. 10th could walk a little without aid.

The paralysis disappeared in the following order: 1, sphincter ani; 2, bladder; 3, ptosis and diplopia; 4, swallowing and speech. When returned to his friends, on Feb. 4th, he was still tottering in gait, and had general muscular weakness. Seen again May 2d, had improved, but was weak; his gait was jerky and feet were lifted high. Knee-jerk normal. No actual ataxia. Paræsthesiæ of pins and needles in feet, and felt "something wrong" in his head. Memory is defective and conversation fatuous.—*Austral. Med. Gaz.*, Aug., 1890.

Pope (P.) on Five Cases of Lightning-Stroke Occurring Simultaneously.—On Saturday, August 2d, whilst a cricket-match was being played on the club ground of the Aldershot Division at Aldershot, five men (privates in the regiments stationed there), who were onlookers, were struck by lightning and severely injured—one fatally. Being present at the time, and having assisted in rendering immediate aid to the unfortunate men, my observations may possibly be of interest. I will preface my remarks by mentioning that the storm had shown but few symptoms of its close proximity. Heavy clouds had been observed approaching from the north, and but one or perhaps two flashes of distant lightning observed. No rain had fallen, and the match was in actual progress when the fatality occurred. On the north side of the ground is a row of small trees, chiefly beeches and poplars, and under these trees were congregated many of the men who, stationed at Aldershot, were watching the match. The unlooked-for flash of lightning, with simultaneous thunder, which I can best describe by com-

paring it to the bursting of a shell, was immediately followed by cries for help by the unfortunate men under one particular tree which had been struck, and a piece of bark about three feet from the ground detached. The size of the piece was about two feet long by six inches wide. Surgeon Trask, who was also playing in the match, and myself at once hurried to the spot. The flash was immediately followed by heavy rain. For the sake of convenience I will describe the cases under numbers, No. 1 being the most severely injured and No. 5 the least injured. The men were carried out from under the tree, and immediately examined. No. 1 was found to be dead; the respiration and pulse had ceased. Artificial respiration was persisted in for some minutes without avail. The face was florid, and the heat of the face and body appeared to the hand to be above the normal. (The man had been for some time watching the match, and was therefore not heated by exercise.) The conjunctivæ were congested, pupils dilated, eyes open. The hands were not clenched, and all the muscles appeared flaccid. There were no marks of injury to the head or face. This man had been sitting on the ground with his back to the tree, and the piece of bark mentioned above was detached just above his head. His comrades who lifted him described his head as being stuck to the tree. There were no marks (as I mentioned) on the head, and no hair on the tree, and I attribute their description of the man's state to the weight of a dead man's head falling backwards. No. 2 was quite unconscious. The respiration had ceased; the pulse was still perceptible. There were marks of burning (resembling ecchymoses) on the left side of the face, neck, and upper part of the left side of the chest, which appeared to branch off from the greatest part of injury on the neck and shoulders, forming the arborescent lines described in text-books; but they did not appear to me to resemble in any way the "photograph of the tree." The hair on the left side of the head was burnt and singed. In this case artificial respiration was rewarded after some minutes by a gradual return to consciousness. Brandy was administered. As soon as possible the patient was covered with blankets and removed to the pavilion, and later to the Cambridge Hospital, Aldershot. In this case also the conjunctivæ were congested (the pupils I did not see till some minutes after the shock). As vitality returned the patient complained of severe pain in the legs. (This was the remark of all those badly injured who recovered. They were not paralyzed.) He was restless, semi-conscious, pulse feeble, and somewhat quick. The condition reminded me more of the state described as reaction with excitement which is seen in concussion of the brain than in any thing else. The patient vomited. During this condition he was removed to the hospital. Nos. 3, 4, and 5 were able to be assisted at once to the pavilion; they were placed in the recumbent position, and stimulants administered. Consciousness returned some few minutes after being struck. Before being removed to hospital they were able to answer the following questions. They none of them remembered being struck, or calling out immediately afterwards. They felt nothing until they returned to consciousness. No. 3 complained of severe pain in his head, his left arm, and both legs, especially the legs. The lower limbs were not paralyzed; the pains in no way resembled "pins and needles," but severe, sharp, continuous pains down the whole length of the thighs and legs at back. No. 4 complained of pain in the left arm and leg similar to No. 3; no pain in head. No. 5 complained of pain in both thighs and legs from the hips downwards, especially at back; no pain in the head. Nos. 3, 4, and 5 did not vomit. The survivors all stated that they felt quite warm, and did not feel cold at any time.

For some minutes after the occurrence the atmosphere smelt most strongly of fire, the fumes being slightly sulphurous, resembling more the smell that is generated by electric sparks given off from a very large dynamo. Several others near the spot were knocked down by the electric current, but did not receive injuries necessitating medical assistance. Most of the players in the field experienced a "shock"—some mildly, others more severe.

P. S.—Since writing the above I have courteously been informed by the surgeon in charge (Cambridge Hospital) that the men all progressed favorably, and returned to duty a few days afterwards.—*Lancet*, Oct. 4, 1890.

Demme on Alcohol in Childhood.—Professor Demme, of Berne, at the recent International Alcohol Congress at Christiania, presented an interesting report of an

investigation which he had made as to the influence of alcohol upon children. Having unusual opportunities for this study from his position as superintendent of a hospital for children, he selected two groups of ten families each, under similar external environment. One group of 57 was manifestly affected more or less by alcohol; the other of 61 was unaffected, or at least very little affected. Of the 57 who exhibited the effects of alcoholism, 20 had inebriate fathers, the mothers and grandparents being moderate drinkers. Only 45 per cent. of these (9) had healthy constitutions; 31 had inebriate fathers and grandfathers, but temperate mothers and grandmothers. Only 2 of these, or a little over 6 per cent., were healthy. Six children had parents and grandparents intemperate; 1 of these survives, a sufferer from epileptic seizures. In remarkable contrast is the state of the 61 children belonging to temperate families, 82 per cent of whom enjoy good health, 3 have died, and 8 are in bad health. Professor Demme also reported the results of an experiment on several children, from whom all intoxicants were kept during eight months, and to whom the usual allowance of wine and water was given during the remaining four months of the year. These children were reported to have slept more soundly and longer, and to have appeared in better spirits and more active, during the non-alcoholic eight months than during the alcoholic four months.—*Brit. Med. Jour.*, Sept. 27, 1890.

Robinson (Alex.) on a Case of Acute Dementia Treated by Hot Water and Electricity Applied to the Head.—The patient was a female, aged twenty, with typical acute dementia. The hot-water treatment was applied daily for one hour by means of a water-cap on the head kept at 110°. This was continued two weeks, after which the temperature was reduced during the latter half of each seance to icy coldness. Distinct improvement was noted in three weeks. Massage was also employed. Later a 4-milliampère galvanic current was passed through her head every second day. She recovered entirely in a little over three months. The author says there was no improvement until the head was treated. He also said the case had a further interest in the fact that it was a case of acute insanity treated in a general hospital—the Glasgow Infirmary.—*Glasgow Med. Jour.*, Oct., 1890.

Training of Nurses for the Insane.—A committee of the Medico-Psychological Association of Great Britain recommended the following system of training attendants, at the meeting of July, this year, the report being unanimously adopted by that body:

a. A period of three months' probation.

b. A period of two years' training and service in the asylum (including the period of probation) to be required before a nurse is allowed to become a candidate for examination.

c. System of training by (1) *study* of prescribed text-books according to the discretion of the medical superintendent; (2) *exercises* under head and charge nurses; (3) *clinical instruction* by the medical staff; (4) *lectures* or *demonstrations* (other than ward instruction) given by the medical staff, at least twelve of which shall be attended by each attendant during his two years' training; (5) *periodical examination* to test progress at the discretion of the medical superintendent.

d. Scope of training should be limited to the ordinary requirements of nursing of, and attendance on, insane patients, combined with instruction in the general features of mental disease, together with general ideas of bodily structure and function sufficient to enable nurses under training to understand such instruction and to qualify them to render "first aid," especially in the case of accident or injury.

The committee further recommends that examinations for the purpose of granting certificates of proficiency to successful candidates be instituted by the association under the following among other conditions:

(1) Examinations to be held twice yearly, and at individual asylums, wherever there may be candidates.

(2) The papers to be set by the examiners for the medical diploma of the association, and the examinations to be conducted by the medical superintendent of the asylum and an assessor.

(3) The candidates to obtain a certificate of moral character and suitability from his or her superintendent before being admitted to the examination.

(4) Attendants who, at this time, or at any time before two years after the institution of this scheme, shall have been afforded and have availed themselves of opportunities of training to an extent con-

templated under the first recommendation, even if it be not exactly in conformity with the prescribed regulations, shall be allowed to present themselves for examination if the council of the association approves.—*Med. Press*, July 30, 1890.

Wolff (Julius) on the Treatment of Writer's Cramp and Allied Affections.—The *Brit. Med. Jour.* of July 19, 1890, contains a communication on giving Wolff's noted method of treating the professional neuroses in his own words:

For the cure of this disease I employ, as is already known, massage and gymnastic exercises, both of which, in addition to the material and mechanical influence which they exercise upon the various functions of the nerves and muscles, have the far more important and essential object of acting upon the psychically affected centre—that is, upon the morbidly affected will of the patient,—and thereby to moderate the action, or, rather, by drawing the attention from the affected point, to influence some new action of the mind. This is my real secret; the most untiring and intelligent practice and an exact knowledge of the ailment and of the patient are required in order that the best material and moral effects may be attained by directing the attention and the comprehensive powers of the patient to a neutral field.

Whilst this is being done in a suitable manner, I endeavor by active or passive, special or general movement, as the case may require, to strengthen the muscles, above all other things trying to gradually stimulate the usual morbid movements to a different action by means of involuntary contrary movements suitable to the case and the patient, continuing this treatment until the patient, without knowing it, and almost without intending it, habituates himself quite mechanically to the passive regular movements which I have taught him to execute. As a matter of course, to ensure success in a manipulation so delicate, the gravamen lies in the efforts being exclusively directed to get absolute command of the attention and the will of the patient, which presents no very serious difficulty, when the attention of the patient, for a time at least, is drawn from this disease, by any amusement or occupation unfamiliar to him, even should the disease be accompanied by pain.

In a case of this kind, where the disease is usually not painful, the active operator should find no difficulty in making the patient gradually lose his nervousness, which is important and indispensable for effecting a cure. This may be effected by the rational employment of massage and gymnastic exercises, which, under the direction of an able, practical, and expert practitioner are, in most cases, perfectly successful. There being, as already observed, only certain groups of muscles and certain nerves involved, which can be exactly determined by special movements, particular attention must be paid to the treatment of these, and as soon as the patient is able to effect the prescribed movements with the arm, hand, or foot readily, freely, and regularly, he is in a fair way to a speedy and complete recovery. As in writing or in playing certain instruments, a number of small muscles are set in motion, it is, in cases of this kind, necessary to continue the treatment for a somewhat longer period, as not only must the new movements be perfectly learned, but the old ones be entirely forgotten. The patient must assist by perfect confidence and great diligence.

In all cases where a patient, aided by practical advice, followed my treatment, and was convinced of its usefulness and efficacy, the success was always complete, and a permanent cure effected. The latter, however, depends entirely upon continuing the gymnastic exercises which are necessary, even after the treatment is discontinued, to ensure the permanence of the effect. Cases of relapse have as yet not occurred to me, although I fully admit their possibility in cases where the patient neglects the prescribed gymnastic exercises.

The true reason of the major part of functional cramps is to be found in a peculiar neurosis, manifesting itself in altered peripheric muscular action.

Curious Adventure of a Hypnotic Subject.—The *Lancet*, Aug. 2, 1890, contains the following interesting episode: In Rome the other day, in that church of the Ara Cœli where Gibbon, as he himself tells us, conceived his "History of the Decline and Fall" of the empire, a young man of foreign appearance, about five in the evening, was seen to be making the round of the several chapels. Suddenly he stopped before the altar of S. Francis of Assisi and remained in rapt attention before the picture of the saint. More than an hour elapsed and he was still seen standing, perfectly motionless, his eyes fixed on the well-

known painting. At last the *custode*, as it was time to close the church, told him that he must withdraw. The stranger seemed not to hear, and moved neither a foot nor a muscle, still gazing as if in ecstasy at the picture. The *custode* shook him and urged him to go, but in vain, till at length the Municipal Guard were called in and the young man was lifted bodily from the pavement and taken first to the station-house and then to the Ospedale della Consolazione. The guard had tried to bring him to consciousness by dashing water in his face and shaking him, but finding these measures ineffectual—the man remaining with his eyes fixed on some invisible object above and not a muscle of his body stirring—they brought him to the medical waiting-room of the Consolazione. There the physicians immediately pronounced the case to be one of hypnotism, and after various remedies had been tried without success, they at last succeeded in bringing him to consciousness by hypodermic injections of ether. On coming to himself, the patient turned out to be a Bavarian, and one of the attachés of the German Embassy, who had been summoned, identified him as a young recently graduated physician of Munich, who had been subject to hypnotic fits for some time past. Thanking all the officials—medical, municipal, and diplomatic—for the care and kindness he had experienced at their hands, he returned to his hotel. The Roman press, commenting on the occurrence, remarks that two or three centuries ago, the same phenomenon would have been regarded as treasure-trove by the church, and the chapel of S. Francis of Assisi, in the Ara Cœli, would have attracted crowds of pilgrims eager to come under the direct influence of the saint. Medical science, however, may now say: "Nous avons changé tout cela."

Sternberg on the Tendon Reflexes.—Dr. Sternberg, of Vienna, read a paper before the Ninth Congress of Internal Medicine, based on observations made on 1,500 patients in the clinics of Professor Meynert and Dr. Redtenbacker. The object of the experiments was to determine the "components" constituting the tendon reflexes—that is, the effects produced by shaking of the muscle, the tendons, the bone, etc., and to separate these various phenomena from each other. In this way he succeeded in showing that the so-called tendon reflexes consist of two phenomena, namely, a bone reflex and a pure muscle phenomenon, which, most probably, is also a reflex. The bone reflex consists in the fact that a shock to the bone, particularly in the direction of its longitudinal axis, irritates the nerves of the periosteum and the articular surfaces, and this produces a contraction of all the muscles belonging to the bone. The muscle-reflex consists in the fact that a stretched muscle becomes contracted when a shock is transmitted to it in the longitudinal direction. The tendon only plays a mechanical part. No reflexes originate from the nerves of the tendon. The existence of reflexes of the fascia cannot be proved. In contractures occurring after localized cerebral affections in various diseases of the spinal cord and in articular processes, the tendon reflexes are invariably increased. In contractures which occur in large cerebral hemorrhages, cerebral tumors and abscesses, uræmia and meningitis and paralysis agitans, the tendon reflexes are never increased, and very frequently are diminished. These two forms of contracture can occasionally be distinguished by the tendon reflexes. In conclusion, Dr. Sternberg pointed out that when all the precautions recommended by Schreiber and Jendrassik for the examination of the tendon reflexes were observed, complete absence of the tendon reflexes was much more seldom found than on less careful examination.—*Brit. Med. Jour.*, June 7, 1890.

Surgical Operations under Hypnotism.—Since sporadic cases of operations undertaken upon hypnotized patients are here and there reported in the journals, it may not be amiss to call attention to the famous experiments in this direction of Dr. Esdaile in India. It cannot be better done than by quoting the following from a letter of Dr. Wilks to the *Lancet* of May 24, 1890:

"The subject was investigated in a genuinely honest and scientific spirit by a committee of Indian medical men appointed by the government to report on the methods being practised by Dr. Esdaile in the performance of painless surgery. 'By order of the Deputy-Governor of Bengal, dated July 31, 1846, the following gentlemen were appointed a committee to observe and report upon surgical operations to be performed by Dr. James Esdaile upon patients under the influence of alleged mesmeric agency: J. Atkinson, E. M. Gordon, J. Jackson, D. Stewart, W. B. O'Shaugh-

nessy, James Hume, A. Rogers.' On October 9th they had their first sitting, and made their report, Dr. O'Shaughnessy being the secretary. Dr. Esdaile did not himself mesmerize, but employed native assistants, and the process took several days to complete, generally about two hours daily for a week. Some persons failed to be influenced. The patient lay on his back, the mesmerist seated behind him at the head of the bed, leaning over him, the faces of both nearly in contact; passes were made with one or both hands along the face, chiefly over the eyes. The mesmerist breathed frequently and gently over the patient's lips, eyes, and nostrils. When he was at last affected, he appeared to be in a deep sleep; he could not be roused by loud noises; the pupils were inactive to light, and apparently there was perfect insensibility to pain on burning, pinching, and cutting the skin. The mesmerizer finally awoke the patients by blowing on their face. On the first trial ten male Hindoos were operated on, mostly for elephantiasis scroti.

"The first case was that of removal of a tumor. During its excision the patient never moved, nor did his countenance change, and when he awoke he declared he had no recollection of the operation. In another case of amputation of the thigh for gangrene, no sign of pain was evinced. In a third case of severe operation the patient moved about, but, on awaking, said he knew nothing of what had been done. In a case of double hydrocele the patient made no expression of pain when the trocar was thrust in. In those cases where movements took place, and the face altered in expression during the use of the knife, the patients, without exception, declared they had no knowledge of any operation having been performed. After this the committee had several sittings, during which operations of various degrees of severity were performed, and on most occasions there were certain persons who failed to be influenced by the mesmerizer. Some very severe operations were undertaken on mesmerized patients without their being at all conscious of what was being done. One man had a large scrotal tumor removed, and when he was awakened he was asked as to the nature of his disease, and why he had come to the hospital. He answered to have the tumor cut off, and when the cloth was removed and he found it gone, he said he knew nothing of it, and exclaimed: 'My life is saved! It is the work of God.' Another patient who had been mesmerized was brought into the room, and was pricked all over with the point of a knife, even to the fetching of blood, but no manifestation of consciousness took place. Sometimes the mesmerist seated himself immediately before the patient, their faces almost touching, and then passes were made over him. In one case deep sleep came on in ten minutes, the pupils were contracted to a point, and the eyeballs drawn to the inner corner of the orbits. In most of the other cases the pupils were described as natural in size. All the members of the committee were satisfied with the facts, and suggested further investigations. I would recommend all those interested in the subject of hypnotism to read this valuable report of the committee appointed by the Indian government in 1846."

OCCASIONAL REPORT ON DISEASES OF WOMEN.

Michinard on the Local Treatment of Chronic Inflammation of the Endometrium.—The author's experience is based upon the treatment of about six hundred cases.

Where acute or chronic salpingitis exists (and this is not an infrequent accompaniment of chronic endometritis, whether resulting from gonorrhœal infection or other causes), it is carefully treated before attempts are made to touch the endometrium.

In nulliparæ the small os externum is cut in four directions with a narrow bistoury; the canal, to a little distance beyond the os internum, is then slightly dilated with Atlee's small dilator. This procedure allows the escape of a large quantity of thick, ropy, slightly bloody mucus, which, accumulating between the internal and external os, gradually expands this portion of the canal, forming a capacious pouch. This mucus, as a rule, is too thick to escape through the small virgin os as fast as secreted, and consequently collects within the canal. Being very tenacious, a certain quantity adheres to the mucous membrane, interfering with the direct application of drugs to the diseased tissues. In my cases, swabbing out the

canal with tampons of cotton has proven an unsatisfactory method of cleansing. To attain this object, I have had made dull curettes. The small one measuring about $\frac{3}{16}$, and the large measuring only about $\frac{5}{16}$ inch. The shank of this little instrument is made of material which, while pliant, offers sufficient resistance to admit of all necessary force being made to the parts. With this curette the membrane is thoroughly cleared of all adhering mucus. Should bleeding accompany this process, the blood is removed with absorbent cotton smoothly wrapped around the ordinary platinum applicator. A second applicator, similarly armed, and saturated with the fluid extract of hamamelis, is then introduced as high as the body, and there left for five minutes. In some patients, a pencil 2 inches long and about $\frac{3}{16}$ inch in diameter, composed of three grains of iodoform and two grains boracic acid, with sufficient cocoa butter and wax, is introduced and kept in place by means of cotton tampons. Both curetting and application are repeated two or three times weekly, care being taken to avoid all treatment five days prior to and five days directly after menstruation. With women who have borne there may be no need of dilating the cervical canal. Under this treatment no unpleasant symptoms have developed, while most excellent results have been obtained in ordinary chronic endometritis.

Where there is slight hypertrophy of the mucous membrane, with enlargement of the papillæ, the small, slightly sharp curettes referred to, and which measure the same as the dull, are used. This instrument is used in my office.

But in those cases following abortion, where there exist "small islands of decidual cells with small-celled proliferations going on around them" (Hart and Barbour), as well as in such associated with troublesome and distressing metrorrhagia, where there is "great hypertrophy of the mucous membrane with increase of all its elements, dilatation of the lumina of the glands, enlargement of the blood-vessels, and marked cellular infiltration of the connective tissue" (Olshausen), the Roux curette is used, preceded by dilatation with Wharton's dilator. In domiciliary practice, the latter cases, for the first two weeks, are treated at their homes, and are required to remain abed at least fourteen days; excepting at the initial application (where carbolic acid is sometimes used), the witch hazel or iodoform pencil is resorted to. Thus far I have had no occasion to regret these procedures. No distressing metritis or dangerous salpingitis has followed.

The vast majority of patients use the vaginal douche treatment so bunglingly that I have become discouraged with its use, and now seldom order it, excepting for cleansing purposes.

I have been so disappointed in the results of trachelorrhaphy that, excepting where great hypertrophy exists with the laceration, I no longer press the operation. Only where the displacement of the uterus is backward, a malposition which interferes with the draining of the canal and which encourages engorgement, is the position noticed.—*New Orleans Med. and Surg. Jour.*, Oct., 1890.

Barnes (R.) on the Correlations of the Sexual Functions and Mental Disorders of Women.—The author strongly urges an examination of the pelvic organs in every case of puerperal insanity. Imperfect involution of the uterus is in the highest degree probable. In addition to other facts, the function of the breasts is almost always suspended. Thus a most potent stimulant to involution is wanting. Retroversion or retroflexion is very possible. Relief from these conditions cannot fail to be beneficial, and may even bring about recovery.—*Med. Press*, Oct. 15, 1890.

Price (J.) on Certain Causes of Major Pelvic Troubles, Traceable to Minor Gynecology.—The popular cry for "conservatism" and preliminary treatment of cases requiring operation is not a scientific plea, but, in most instances, a *personal bid* for indulgence by those who try to accomplish something, without acknowledging on the one hand that there is little or nothing to encourage them in their work, so far as results are concerned, and on the other, there is abundant proof that manifold and really major surgical affections arise merely from treatment recognized as orthodox from the standpoint of minor gynecology. Dr. Price does not hesitate to put minor gynecology in a causal relation with a vast amount of the necessary major pelvic surgery.

First among these causes may be mentioned the Emmet cervical operation. Like many other cervical operations, this, when first described by its distinguished originator, was done by every surgeon, without

the least consideration of its contra-indications. Very many minor tears of the cervix, in which only a cosmetic effect is obtained by operation, are made distinctly worse by operative interference. In many cases the pain becomes insufferable, from the lighting up of a dormant or unrecognized pelvic trouble, and an operation is required to undo the mischief of an unnecessary cervical closure. This fact has been recognized by Emmet himself, and he has counselled the careful selection of cases in order to escape these disastrous results. Where there is pre-existing pelvic disease, even though slight, no cervical operation should be attempted unless absolutely required by the condition of the patient.

Another operation which has met with much approval from some men, and which is, apparently, sometimes successful, is the forcible dilatation of the cervix. It is clear that where there is antecedent inflammation of the pelvic viscera—that is, of the genito-urinary system, such an operation as surgical dilatation of the cervix cannot be free from danger. In order to relieve dysmenorrhœa by this procedure, the condition must evidently be due to stenosis of the os or cervix. The question here arises, Can the cause of dysmenorrhœa be determined? Dr. Price thinks that in some cases it can, but that in many women in whom a stenosis would be expected, there is no difficulty whatever attending the menstrual flux. This being the case, it is evident that a diagnosis cannot be made without a careful study of all the symptoms.

Again, in many women the causes of this condition are complex. It will not do to lose sight of this, and conclude that, because a flexion exists, dilatation will remedy menstrual pain. It is to be remembered that, if there is coexisting pelvic inflammation, dilatation will increase it, and, under certain conditions, cause it, if absent. Rapid dilatation of the cervix is a traumatism, and is attended with all the dangers of septic absorption as is any other violent procedure, and where traumatism incident to natural causes is confessed to be the cause of so much subsequent mischief, it should not be *expected that operative injury can be harmless.*

This conclusion, reached inferentially, has been abundantly confirmed practically on the operating-table by much of his later pelvic work. In a number of cases with a history of preceding dilatation, the after-operation shows an exceedingly complicated and inflammatory condition. Some of the dilatations were done during pre-existing disease, which was made worse by the interference, while others were done on uncomplicated cases to relieve the dysmenorrhœa, and resulted in the establishment of a disease in which operation was necessary to save life.

Judged simply by its remoter effects, the operation of rapid dilatation is a dangerous one, and results oftener in subsequent harm than in lasting good. The surgical injury to the cervix is, in many of these cases, more pronounced than the tears of the cervix, which are closed by Emmet's operation.

Simple closure of lacerations of the cervix in cases of pelvic disorder almost certainly exacerbate the symptoms. The necessary inflammatory action set up in the suture-tract is transferred along the lymphatic or venous channels to the seat of the earlier inflammation, until a pelvic peritonitis is kindled or rekindled, which at last entails abdominal section. The minor gynecologist, who has no regard for or appreciation of the relation of the commonly advocated general closure of perineal and cervical tears to major surgical complications, cannot but be a great factor in the causation of the same.

That the inconsiderate use of the uterine sound has been responsible for much inflammatory pelvic trouble is scarcely to be disputed. This is not because the sound is of itself a dangerous instrument, but because it is used by every tyro as an instrument of diagnosis. If used at all, it should be in the hands of those with whom its application, by reason of their skill, will be exceptional, and in the hands of the non-expert its use should be forbidden. The indiscriminate use of the sound and electrode is the most serious mechanical objection to the employment of electricity. Every sitting for the electrical treatment is prefaced by the use of the sound, and necessarily followed by the introduction of an electrode of some form. This is by a class of men who, usually, have had no previous gynecological training or education whatever. In such hands such methods can only be harmful, and we are now reaping the fruits of their work in a class of pelvic operations not surpassed in the complications presented. In the same category with the sound may be placed the

curette. Dilatation, with curetting of the uterus, has been the cause of a long series of major operations.

Another class of cases coming under this head are those in which many intra-uterine applications have been made with such agents as nitric acid, chromic acid, and nitrate of silver. For a woman to have undergone a routine treatment with these caustics, and to have escaped pelvic inflammatory trouble, is little short of a miracle. —*Med. News*, Oct. 18, 1890.

Skene (A. J. C.) on Injuries to the Ureters during Labor.—The patients observed by the writer had usually been primiparæ or had had many children; the labor had been tedious, instrumental, or manual, and the progress after delivery satisfactory or fairly so. The lochial discharge and the secretion of milk had been normal, and the bowels and the kidneys apparently normal. In some cases there was retention of urine or frequent and painful urination. Pelvic pain and tenderness in the lower part of the abdomen were present, but were not always severe at first. These symptoms became more acute after a time, the pain and tenderness increased rather abruptly, and a chill might occur at this time. Distension of the bowels took place, and the temperature and the pulse-rate increased. Pressure showed increased tenderness, and bimanual manipulation of the kidney on the affected side usually produced a sense of distress rather than of acute pain. An increase in the severity of the symptoms supervened in from three to five days, and soon thereafter a quantity of pus, and sometimes blood, appeared in the urine. The patient was generally relieved to some extent when the discharge of pus began; the pain was less and the temperature and pulse-rate were reduced a little. In connection with pus and blood, renal casts might be found. The pus continued to be discharged, but in diminished quantity, for a week or more. The bleeding generally subsided in a day or so, and most of the patients recovered. In some other cases acute disease of the kidneys appeared about the time that pus began to be discharged from the bladder; uræmia followed, and sometimes uræmic coma. Such cases usually terminated fatally, although recovery might take place. In most instances there was not a pre-existing renal disease.

The diagnosis of injury to the ureter must be made by the exclusion of the more common puerperal affections—such as peritonitis, cellulitis, general septicæmia, cellular abscess, and cystitis. If there was a metro-cellulitis following injury to the cervix uteri, the ureters became affected secondarily, and the symptoms developed in reverse order.

The following was a convenient classification of diseases and injuries of the ureters: 1. Injuries of the ureters during labor. 2. Obstructions to the ureters secondary to pelvic inflammations. 3. Obstructions due to neoplasms and uterine displacements. The second and third were taken from Engelmann.

Injuries to the ureters might be avoided in great measure. Care to dilate before rupture of the membranes, the proper use of the forceps, and having the patient in the best possible physical condition, were essential as prophylactics.—*N. Y. Med. Jour.*, Nov. 1, 1890.

Davenport (F. H.) on Incontinence of Urine Due to Malposition of the Ureter.—The patient was twenty-nine years of age, and gave a history of having suffered from incontinence of urine all her life, being constantly wet. The leaking was constant, and not affected by position or by straining or coughing. The amount varied within certain limits, from two to eight napkins being used daily. Menstruation and pregnancy increased the flow.

There was no cystitis in this case, and her usual medical attendant had corrected a malposition of the uterus, and had used electricity, belladonna, and other remedies, but without appreciable effect.

Examination revealed a malformation of the ureter. Instead of turning into the bladder at the normal position, the ureter was continued along in the septum between the bladder and the vagina, and emptied by a special opening near the meatus.

The treatment indicated in this case was, if possible, to dissect up the ureter from its bed in the anterior vaginal wall, to a point corresponding to where it would normally enter the bladder, make an opening into the bladder, turn the ureter in and fasten it there, and then close the fistula. This operation was performed, sutures of silver and catgut being used. Subsequent retraction of the ureter rendered a second operation necessary, in order to fix the end of the ureter. This operation was a complete success.

Dr. Davenport states that this variety of ureteral malformation is extremely rare, and that there are records of only a few cases in which operation has been attempted.—*Boston Med. and Surg. Jour.*, Oct. 30, 1890.

Du Cane (E.) on Uterine Inertia Following Ovariotomy.—E. D., aged thirty-two, after having had several (four) children, was discovered, when pregnant about five months, to be suffering from an ovarian tumor. This tumor, which proved to be cystic in nature, was removed by Mr. Thornton at the Samaritan Free Hospital, and she was subsequently delivered at full time. Nearly three years elapsed, and she became again pregnant; the labor progressed until full term, labor pains commenced, continued for a few hours, and then entirely ceased. Her medical attendant gave ergot without any effect, and then delivered her of a still-born child by means of forceps. A profuse post-partum hemorrhage followed. Two years again passed, and another pregnancy ensued. When called to the case I elicited the above history, which I subsequently confirmed. The pains, which were of the ordinary character, continued for four hours, and then entirely ceased. I tried massage of the fundus, expression of the fœtus, and then, unwillingly, exhibition of ergot, all without effect. The os was fully dilated, but the head was very high up. I attempted the high operation with Galabin's long forceps, but as I experienced some difficulty I resolved to perform podalic version. I therefore turned by the internal method, and delivered her of a living female child. There was no trouble with the placenta, which I expressed after an interval of fifteen minutes, subsequently kneading the uterus to induce full contraction. She had no post-partum hemorrhage, and made an uninterrupted recovery. The case seemed to me interesting with reference to Tyler Smith's "ovarian" theory of labor, as I thought the uterine inertia in such a marked degree following the removal of one ovary might be accounted for by that fact.—*Lancet*, Aug. 30, 1890.

Hulbert (Geo.) on Mechanical Obstruction in Diseases of the Uterus.—The author does not believe that stenosis was a dominant factor, and rejected *in toto* the prevalent theories of dysmenorrhœa. Out of over 10,000 cases examined *intra vitam* and 300 examined *post mortem* in no single case was he able to demonstrate an obstruction that would hinder the ready flow of blood, save in the cases of pure atresia. By means of drawings made from post-mortem specimens he demonstrates that stenosis could not come from a simple bending because of the atrophy that took place at the angle. It would not do in these cases to draw conclusions from forcibly bending a normal uterus or a rubber tube—the conditions were quite different. He regards the pain in the so-called mechanical dysmenorrhœa to changes in the nervous and vascular supply of the uterus, caused by general conditions. He is confirmed in these views by the fact that an internal os with an opening of about 1-32 inch could discharge 120 times the normal amount of menstrual fluid; also, by the fact that 50 per centum of cases presenting all the physical conditions of stenosis—impermeability to the sound, pinhole os, etc., never had any pain.—*Jour. Am. Med. Ass'n*, Oct. 18, 1890.

Tapeworm as a Cause of Dysmenorrhœa.—Dr. Isidor Pálmai of Budapest reports in the *Gyógyászat* a case in which a tapeworm apparently caused dysmenorrhœa and sterility. A young married woman of twenty, who had suffered for ten years from tapeworm, consulted Dr. Pálmai for persistent diarrhœa. The patient was anæmic and complained of all kinds of troubles, and more especially stated that she suffered intense pain during menstruation. She had no child, although she had been married three years. Five or six times the expulsion of the tapeworm had been attempted without result, owing, as the patient believed, to the fact that she brought up the anthelmintic immediately she had taken it. Dr. Pálmai gave her a perfectly fresh infusion of filix mas, and was successful in expelling the tapeworm in its entirety, measuring nearly eleven feet. After some days the patient lost the unpleasant feelings she had had and the depression of spirits. She conceived almost immediately, and was delivered after a protracted labor of a perfectly healthy child by means of forceps. Since then the menses have been quite painless. Dr. Pálmai considers that the dysmenorrhœa and the sterility, as well as the subsequent unsatisfactory labor pains, were due to the prior influence of the tapeworm on the nutrition of the circulation and the condition of innervation of the uterus.—*Lancet*, Nov. 1, 1890.

REPORT ON DISEASES OF THE EAR AND EYE.

BY A. T. MUZZY, M.D.

Jones (H. M.) on the Etiology of Tinnitus Aurium.—From my experience we may place the proportion of aural patients suffering from tinnitus as about one in three. The kinds of noises found are the following: sound resembling buzzing; sea roaring; trees agitated; singing of kettle; bellows; bee humming; noise of shell; horse out of breath; puffing; thumping noise; continual beating; crackling sounds in the head; train; vibration of a metal; whistle of an engine; puffing of steam-engine; furnace blowing; constant hammering; rushing water; sea waves; drumming; rain falling; booming; railway whistling; distant thunder; chirping of birds; waterfall; mill wheel; music; bells. The age at which the largest number were found was from twenty to fifty, the frequency diminishing either way from this period. In the case of two hundred patients, the following are the causes noted: cerumen, 30; naso-pharyngeal catarrh, 28; nasal turbinated congestion and obstruction, 19; mental worry and overstrain, 14; sea bathing, 12; scarlatina, 9; heredity, 8; tropical effects, 8; the menopause, 8; injuries, 7; hypertrophied tonsils and tonsillitis, 7; abscess or inflammation of meatus, 7; cardiac disease, 7; gout, 5; uterine disorders, 5; measles, 4; syphilis, 4; alcohol, 4; rheumatic fever and rheumatism, 3; pregnancy, 2; morbus Brightii, 2; ozæna, 2; decayed teeth, 2; facial paralysis, 1; puerperal septicæmia, 1; quinine, 1; adenoid growths, 1; from gun concussion, 1; pneumonia, 1; parotitis, 1. Right ear alone, 36; left ear alone, 53; both, 171. Clinical conditions found: cerumen, 30 (those cases of cerumen where it was secondary, and evidently not the cause of tinnitus, not included); inflammation or abscess of meatus, 7; exostosis of meatus, 7; catarrhal changes in tympanum, 102; same with closed Eustachian tube, 38; perforation of the membrane, 17; polypus in the tympanum, 4; disease in the labyrinth, 47; nasal obstruction, 19; tonsillar hypertrophy, 7; cretaceous membrane, 1; both ears normal, 26; one ear normal, 7. No cause was ascribed for the tinnitus in three of the cases of normal hearing. *Symptoms:* The main points in 187 cases were tinnitus and deafness. In 22 vertigo was present, 9 of which presented the typical symptoms of Ménière's disease. Dr. Ferrier has given voice to a generally accepted opinion that the sense of hearing is in greater part situated in the superior temporal gyrus of the temporal lobe. It is important to remember that the anterior nucleus of the auditory nerve is supplied with vaso-motor fibres. The different causes of tinnitus may be classified as follows: *Class* 1. Impulses originating in the temporal lobe, or superior temporal gyrus, the cerebellum, or the auditory nuclei (in the medulla or pons), and referred as impressions to various situations, as the labyrinth or certain parts of the head. Such acoustic impressions may or may not be attended by deafness. These impulses may be associated with lesions in these areas, as tumors, apoplexies, effusions, thrombi, or possibly lesions in the adjacent portions of the occipital or parietal lobes. Such impulses may result also from reflected irritations of any of these parts. *Class* 2. Impulses due to irritation direct or reflected in any portion of the auditory nerve. This latter would include hyperæsthesia, atrophy, sclerosis, traumatism, vaso-motor (dilator or constrictor) effects, morbid blood supply to the nerve, as in uræmia, anæmia, or the circulatory changes which occur during pregnancy. These latter causes may also operate under Class 1. *Class* 3. Impulses originating in the peripheral ends of the auditory nerve, due to (*a*) increase or diminution of labyrinthine pressure, increase or diminution of, or encroachment on, the perilymph or endolymph from abnormal pressure on either of the fenestræ; this latter cause would include rigidity of the membrane of the round opening, and fixation of the stapes against the oval opening. (*b*) Vascular changes; increase or diminution of blood pressure, frequently associated with cardiac disease; hyperæmic, anæmic, or toxæmic states of the blood circulating in the labyrinth; apoplexy and extravasations. (*c*) Morbid nerve conditions—hyperæsthesia, paresis (organic or functional), atrophy, sclerosis, traumatism. (*d*) Rheumatic, gouty, or syphilitic states of the walls and vessels of the labyrinth. (*e*) Reflected disturbances through the spinal cord or cerebro-spinal nerves, as occurs in uterine disorders, pregnancy, gastric derangements, disorders of the liver, flatu-

lence, spinal neuroses, dental, nasal, and ocular irritations involving the fifth and facial nerves. *Class* 4. Irritations arising from interferences with intra-tympanic muscles, tensor tympani, and stapedius. Such interferences would include any spasms of these muscles, abnormal changes in the membrana tympani, reflex irritation transmitted from the facial or trigeminal nerves. *Class* 5. Irritations transmitted by altered conditions of equi-libration of the air in the tympanic cavity. This would include enervation of the tubal muscles of the Eustachial tube and altered relations between the air in the tympanic cavity and the blood in its vessels or those of its membranes; also pathological states of the membrane. *Class* 6. Irritations due to disease in the middle ear and labyrinth. This would embrace atheromatous changes in the arteries, aneurismal dilatation, blood extravasations, venous congestion within the lateral sinuses, disease of the mastoid cells, and disease of the petrous portion of the temporal bone, exudations, and tumors. *Class* 7. Irritations arising in the external ear, including inflammation and abscess, ceruminous collections, eczematous inflammation, exostosis and hyperostosis, othæmatous, foreign bodies. Some of these causes act by direct irritation of the nerves supplying the external auditory meatus or tympanic membrane, as in inflammatory attacks and exostosis; others, as cerumen or foreign bodies, by the influence they exert on the sound waves or by the pressure due to their presence on the membrana tympana, and thus conveyed to the ossicles and labyrinth. *Class* 8. True aural hallucinations, subjective impressions arising in the psycho-sensorial brain centres and having no objective cerebral or aural source of origin. Such hallucinations may become insane hallucinations. *Class* 9. Therapeutical causes of tinnitus aurium. The action of such drugs as ergot, nitroglycerine, alcohol, ether, quinine, salicin, caffeine, apomorphine, nitrite of amyl, tobacco, iodine, iodoform, chloride of barium, digitalis, convallaria, atropine, veratrin, duboisin, gelsemin, jaborandi, pilocarpine, monobromide of camphor, hydrobromic acid. Some act by direct stimulatien of the auditory nuclei in the medulla, some on the vaso-motor centre, others on the aural circulation through the heart. As a rule we cannot attribute much harm to the auditory apparatus from use of quinine. The tinnitus of fever is almost invariably transitory.—*Provin. Med. Jour.*, Oct. 1, 1890. A. T. M.

Botey (R.) on Experimental Avulsion of the Stapes in Animals.—The author is convinced that the ossicles and the tympanum are not indispensable to hearing, for he affirms that hearing is retained when the membranes of the fenestra ovale and rotundum are accesible to external sonorous vibrations. He has made a long series of interesting experiments upon chickens and pigeons, which demonstrate:

1. That avulsion of the stapes is, in animals, absolutely harmless.

2. That a new membrane ovale is always formed.

3. All animals operated on hear, even at quite a distance, probably by the fenestra ovale and rotundum.

4. Animals from whom the stapes, as well as other mechanical parts of the hearing apparatus, have been removed, while they retain intact the membrana ovale and rotundum, hear better than those who, other things being equal, have an ankylosis between the fenestrum ovale and the base of the stapes, even if the rest of the auditory apparatus is perfectly normal.

5. If all the mechanical parts of the hearing apparatus are removed except the stapes they hear less than when the two stapes are also removed.

6. The ossicles and tympanum, the author concludes, are not indispensable to hearing, but only reinforce sonorous excitations and increase the hearing distance.—*Bull. méd. du Nord.*, Sept. 26, 1890.

Avulsion of the Ossicles.—At the recent Berlin Medical Congress Stacke spoke on the indications for the excision of the malleus and incus. In order to get a better view of the field of operation Stacke makes a long incision behind the external ear, draws this forward, and then cuts through the wall of the external meatus (just above the drum-head) and pulls it out of the meatus. After removing the ossicula he sews the detached parts together again. He advocates the removal of the ossicula in the following cases: 1. To improve the hearing, in cases of adhesions of the drum-head to the tympanum and in cases of impervious Eustachian tube. 2. In cases of affections of the attic. 3. When the malleus is diseased. 4. In cases of cholesteatoma of the tympanum. He does not

recommend the operation in cases of sclerosis or chronic dry catarrh of the middle ear.

Sexton advocates the removal of the drum-head and ossicles (1) in cases of deafness due to chronic catarrh, including sclerosis. 2. Noises in the head. 3. Vertigo. 4. Chronic otorrhœa.—*Provin. Med. Jour.*, Nov. 1, 1890.

Berger on the Surgery of the Sphenoidal Sinus. — The author is chiefly interested in the visual disturbances produced by diseases of the sphenoidal sinus. He asserts that a narrowing of the optic canal may be produced by an irregular growth of the body of the sphenoid bone.

The mucous membrane of the sphenoidal sinus, being so near the sheath of the optic nerve, might induce, if in an inflamed or catarrhal state, a perineuritis or an acute retro-bulbar neuritis.

The ocular troubles produced by diseases of the sphenoidal sinus are produced either in a reflex way (lachrymation, blepharospasm) or by the direct action of a pathological process on the optic nerve or orbit.

The visual disturbance commences by a limitation of the temporal visual field, which becomes concentric, and finally the macular fibres emerging from the centre of the nerve become diseased. These visual disturbances bear no relation to those occurring with nasal diseases, which are characterized by a concentric limitation. Opening the sphenoidal sinus has given the most favorable results in these cases. The operation is best performed through the nose.—*Jour. de Méd. de Chir. et Pharm.*, Sept. 20, 1890.

Dowling (F.) on the Prevention of Myopia.—Myopia begins usually about the tenth year. It was mostly to be attributed to over-use of the eyes. The condition was hereditary—not directly, but the tendency to it. Deformity and malformations, as well as choroiditis, played a part. The inflammatory exudates stretched the membranes, and so lengthened the long diameter. All children should not study the same number of hours; myopes should have fewer hours and more light. If the general health became impaired, all study should be suspended. Latin letters and larger type should be used, and in myopes reading should be frequently interrupted and the eyes closed or fixed upon a far point. Glasses do not check the myopia, and should not be worn before the fifteenth year. Paracentesis of the cornea is useful in marked cases, and frequently prevents detachment of the retina.—*Jour. Am. Med. Assn.*, Oct. 18, 1890.

Magee (R. S.) on Corneal Ulcers with Special Reference of Their Treatment with the Galvano-Cautery.—After a narration of six cases of corneal ulcers the author concludes:

1. The galvano-cautery is always indicated in those ulcers which take their origin in mycotic infection. In such cases it gives the most thorough disinfection of the floor and sides of the ulcer, and at the same time stimulates the process of repair.

2. Repair is shown almost at once after the application, in the clearing of the aqueous humor, more easily obtained, dilatation of the pupil, absorption of the hypopyon, and increased diffusion of the corneal tissue.

3. In most cases it does away with the necessity of the corneal (Saemisch's) incision; because when the evacuation of the contents of the anterior chamber is required, it can best be effected by means of the heated loop.

4. The operation causes but slight pain—no assistant is necessary.

5. The healing process is considerably shortened, and the final result shows a much less extensive and dense opacity of the affected corneal tissue.

6. In one case it was employed in the early stage, but in four cases it was employed late in the disease, when destruction of the eye seemed certain, and with gratifying results.

7. The pain following the application of the galvano-cautery is less and of shorter duration than that of any other caustic.

8. The extent and limitation of cauterization can be definitely measured—not so with any other caustic.

9. The mode of applying the heated galvano-caustic is exceedingly simple and easy to master.—*Kansas Med. Jour.*, Nov., 1890.

Jackson (E.) on Increase of Hyperopic Astigmatism. — The author thinks that astigmatism is by no means constant in degree, though decided changes are exceptional. Changes in its amount, and slight changes in the direction of its principal meridians must be looked for.

These changes are not due to muscular defects nor confined to any particular period of life.

When a patient comes with lenses prescribed some time previously by a colleague, and which do not now correct the ametropia, we must not jump at the conclusion that these lenses were inappropriate at the time they were ordered.

An unsymmetrical increase in the bulk of the lens the author thinks the most probable cause of changes in astigmatism.—*Med. News*, Oct. 4, 1890.

Lippincott (J. A.) on New Tests for Binocular Vision.—Tests for binocular vision are of two classes: 1, those for determining the presence or absence of uniocular blindness; and 2, those for establishing the existence or non-existence of binocular single or stereoscopic vision. The first includes all methods for preventing the sound eye from seeing. The second refer to the combined action of the two eyes in seeing, or the lack of combination. (1). A + spherical placed before one eye makes the corresponding side of a rectangle appear higher than the other. 2. A — spherical makes the corresponding side appear lower. 3. A + cylinder vertical *increases*, whereas a + cylinder horizontal lessens, the apparent height of the corresponding side. 4. A — cylindrical reverses the plus cylinder. 5. A + cylinder axis pointing upward and outward before either, and still more when before both, makes the top of a rectangle appear narrower than the bottom, while if the axis is changed 90° the rectangle is reversed in appearance. 6. — cylinders reverse the action of the +. 7. Binocular vision is necessary for the production of optical metamorphopsia.

These appearances can be elicited in all persons, ametropes, emmetropes, or anisometropes. Many persons cannot decide whether they see better with both or with one. These tests furnish evidence of the existence or non-existence of stereoscopic vision.—*N. Y. Med. Four.*, Sept. 27, 1890.

Brown (E. J.) on Total Blindness Following Shock; Recovery.—A boy of six years, who had been exceptionally rugged and active, had October 23d a transient attack of headache and vomiting. Nov. 4th he had been seen by Dr. Murray for a transient attack of what seemed to be a cold, accompanied by wandering rheumatic pains in the feet and limbs. Nov. 12th Dr. M. was again called and found a mild tonsillitis with a temperature of 101°. Nov. 14th the mother fell down stairs; the boy was greatly frightened, and was soon seized with a severe headache followed by epistaxis and relief. Light diet had been ordered, but on the 16th he was so well and so hungry that he was allowed to eat a large piece of beefsteak for supper. The following day he had a convulsion followed by total blindness.

When examined Nov. 18th, the boy was nervous and restless but did not complain of pain. Answered questions slowly but intelligently. Sensibility was much diminished in the extremities. The pupils were moderately dilated and both reacted slightly to light, but the left less than the right. The ophthalmoscope showed no changes at the fundus. Dr. Murray was giving small doses of calomel and iodide of potassium. No change suggested. Nov. 20th vision began to return and two days later was fairly good. Dec 3d there was some anæsthesia of the hands and feet as well as diminished control of them. The arms and legs were considerably shrunken, and at times there were pains in the latter. The right pupil reacted sluggishly to light. Vision was good and the fundus normal in both eyes. There was headache at times, but the boy ate and slept well and was steadily improving. Complete recovery supervened.—*Northwestern Lancet*, Oct. 15, 1890.

Bull (C. S.) on Simple Extraction of Cataract without Iridectomy.—The advantages may be summed up as follows: 1. If successful and without complication it preserves the natural appearance of the eye—a central, circular, and movable pupil. 2. The acuteness of vision with the astigmatism carefully corrected is somewhat greater than after the old operation. 3. Eccentric vision and orientation are decidedly better than by the old operation. 4. Small particles of capsule are much less likely to be incarcerated in the wound, and thus act as foreign bodies and excite irritation. 5. It is a shorter operation in point of time, by reason of the absence of an iridectomy. 6. As there is no iridectomy, there is little or no hemorrhage, and this may be considered a very decided advantage. How often do we see an operation for the extraction of cataract delayed, sometimes for many minutes, by extensive extravasation of blood from the divided

blood-vessels of the iris, often filling the anterior chamber and becoming coagulated. Many an operation has been interrupted and the extraction of the lens postponed to a future day, because the hemorrhage from the iris was so profuse as to render further steps of the operation well-nigh impossible, until the blood in the anterior chamber had been absorbed. If blood remain in the anterior chamber after the opening of the capsule and the extrusion of the lens, the coloring matter frequently is deposited in the lacerated capsule, and by its dark color interferes with the ultimate vision. The disadvantages of simple extraction are as follows: 1. The technique of the operation is decidedly more difficult than that of the old operation. The corneal section must be larger in order that the passage of the lens through it may be facilitated, as the presence of the iris acts as an obstacle to its passage. The section must be performed rapidly, so as to avoid the danger of the iris falling on the knife and being wounded. This rapid passage of the knife across the anterior chamber renders it difficult to make the height of the flap an even curve, particularly when the incision is entirely in clear cornea, as it should be. The cleansing of the pupillary space and the posterior chamber is much more difficult than after the old operation. 2. Posterior synechiæ, secondary prolapse, and incarceration of the iris are more frequently met with than after the old operation. The two latter may be largely avoided by making the corneal section in clear cornea, and not in the limbus, which is too peripheral, and rather favors both prolapse and incarceration of the iris. 3. The operation is not applicable to all cases. This objection, however, may be applied to all operations.—*Med. Rec.*, Sept. 20, 1890.

Marlow (F. W.) on Preliminary Capsulotomy in the Extraction of Cataract.—In Dr. Tyner's communication on this subject no precedent for the operation had been found. The same procedure, however, was described by Drake-Brockman in 1884, and possibly earlier; and by Hiemel, of Leipsic, in 1888. Drake-Brockman, in the *Ophthalmic Review*, gives a complete statistical report of two thousand one hundred and seven repetitions of this method. Hiemel's paper was read at the International Congress of Ophthalmology held at Heidelberg in 1888, reference to which may be found in the *American Journal of Ophthalmology* for that year. Three years or more ago this method suggested itself to me, and I thought it original until subsequent reading of Drake-Brockman. Hiemel's paper indicates that he considered himself original in its use.—*N. Y. Med. Jour.*, Sept. 27, 1890.

Tyner (T. J.) on Preliminary Capsulotomy in the Extraction of Cataract.—Supposing the eye to be ready, a Bowman stop-needle is thrust into the anterior chamber, the pupil having been previously dilated. The capsule is lacerated in its upper quadrant, the line of incision corresponding to the upper pupillary curve of the iris. The greatest care should be taken not to lose any aqueous humor. Corneal incision is now undertaken, when the lens will be found to follow the knife-blade as it cuts its way out. The operation is simple and easily done. I have performed the operation twelve times with a good result in each one.—*N. Y. Med. Jour.*, Sept. 20, 1890.

Barr (S. D.) on an Early Extraction of Cataract.—Donders represents the refractive power at its maximum in the child at ten years of age, from which period it steadily decreases until at sixty it is lost entirely. So at sixty we have the lens in a condition of solidity that cannot be changed by any amount of action of the ciliary muscle. I believe the lens at this period is in a better condition for extraction, if that is necessary, than later after retrograde metamorphosis has taken place. In the first condition it is a solid mass of the consistency of gum; the corticle being still adhesive enough to hold well together, and the milky appearance indicating separation of lens from capsule, it can be easily extruded without scaling of any of its particles. Later it becomes atrophied, brittle, and scaly.—*N. Y. Med. Jour.*, Aug. 30, 1890.

Chandler (H. P.) Report of Fifty Cataract Extractions by a New Method.—There are two kinds of operation for cataract broadly speaking, one with iridectomy and the other without. The simple gives better refractive results, and adds a safeguard against escape of vitreous; the other is easier of performance and is surer of securing a clear pupil, and does away with possibility of prolapse or incarceration of the iris. In forty-seven cases the following operation was performed. Immediately after the sclero-

corneal incision a small bit of the iris is caught by forceps one to two millimetres from the periphery and drawn out, and a minute round opening made horizontally in at this spot. The removal of the lens and cortical matter is then performed and the iris finally allowed to recede to its normal position. The purpose for this opening is to allow for the exit of aqueous humor which collects behind the iris, and which would otherwise tend to push the iris into the wound whenever there happens to be loss of tone in its muscular structure.—*Boston Med. and Surg. Four.*, Oct. 16, 1890.

Lippincott (J. A.) on a New Anterior-Chamber Syringe.—Syringing the anterior chamber after cataract extraction was re-introduced to the profession by McKeown of Belfast in 1884. But others very promptly followed in adopting this procedure, though their number is still small. Since October of 1888 to last June, I have practised this procedure in fifty-three cases of cataract extraction. Preliminary iridectomy of varying degree was performed in all cases. Immediately after the corneal incision the inverted T-section of the capsule is performed, and the speculum being removed the lens is removed by application of pressure. The nozzle of the syringe is then inserted and a 1 % sterilized boric solution is flushed through the chamber; generally two to three drachms are sufficient. Only one case experienced any inflammation or irritation. A high degree of visual acuity was gained in a large proportion of cases, 55 % having $\frac{20}{30}$ and over. And in 79 % of the operations the capsule was so clear as to do away with secondary operation.—*Am. Four. Ophthal.*, July, 1890.

Pitts (B.) on Cataract Extraction.—There will never be a time when there will be one universal form of cataract extraction; anatomical and pathological conditions, not to speak of personal fancies and prejudices, will prevent. The object to be attained is the nearest perfect vision, with the least deformity, and of course with the least danger. The technique of the simple operation is undoubtedly more difficult of attainment. This should not weigh against the operation if otherwise preferable. When the corneal incision is made near the sclero-corneal line, prolapse or incarceration of the iris is very liable. To avoid this the incision can be made much farther from this point; the puncture and counter-puncture being made even on the line, but the blade being brought forward and upward and the incision completed some distance from the sclero-corneal boundary. Preference is given to a horizontal incision of the capsule as near its upper border as possible. Then instead of the Valk dilator, a wire loop, described and employed by Dr. Knapp, is used to draw the iris upwards out of the way, while pressure is made from below and the lens readily extruded. In a normal condition of the vitreous there is little danger of its escape by either method. But when it is fluid there is less danger of escape with iridectomy than without, for while in the first the comparative nearness of the incision to the posterior chamber and the absence of support that the iris gives, rather invite disaster, yet in the second the increased manipulation, force, and pressure are much more conducive to its escape. Lately irrigation of the anterior chamber for removal of detritus has given good results, and furnishes a safe means for operating much earlier, than formerly, in the history of the cataract.—*Med. Record*, Oct. 18, 1890.

MEDICINE AND PATHOLOGY.

Pritchard (O.) on Upwards of Forty Operations for Cancer with Escharotics.—The Michel paste is, in my opinion, infinitely superior to any of the other escharotics. It will do as much work in one hour as any of the others will do in a week. When properly applied and in favorable cases, it will destroy completely the largest tumors of the breast in eight or ten hours, and with care it may be so managed that the patient should feel nothing whatever of it from beginning to end. Neither the composition nor the mode of application of this valuable escharotic is, as far as I know, described in any text-book on surgery, and consequently it is hardly known to the profession. It is therefore necessary to describe this more carefully. The paste consists of one part by weight of asbestos cut small and rubbed down in a mortar or between the hands into fine powder, to three parts by weight of Nordhausen or fuming sulphuric acid, mixed together into a paste on a glass or porcelain slab, with a silver, or, better, a glass spatula. This

acid must not be confounded with the pure sulphuric acid mentioned in some text-books. They differ widely, both in their composition and in their action. The latter is an exceedingly painful application, and simply chars and hardens the tissues, while the Nordhausen acid is not nearly so painful, and under its powerful hygroscopic action the tissues almost disappear, and what remains of them becomes a soft cheesy non-adhesive mass of cells which crumbles away when touched. The Nordhausen acid is not a definite chemical compound, but a mixture of sulphuric acid and sulphuric anhydride ($H_2SO_4+SO_3$). It should have a specific gravity of 1.9, that of pure sulphuric acid being 1.84. It is a very delicate and unstable preparation, and unless very carefully manufactured and preserved it is apt to become crystallized into a solid mass. It absorbs water so rapidly from the air that if exposed for a short time, it becomes quite useless as an escharotic. It will thus be easily understood that the paste must be made fresh for each application.

I cannot describe the mode of applying the Michel paste better than by giving my notes of a recent case which I think illustrates a suitable subject for such treatment, and also a very successful operation.

Mrs. F——, sixty-eight years of age, has had a slight induration in the right breast since the birth of her first child, but no pain or trouble until three or four months ago, when it began to grow very rapidly, and soon involved the whole of the gland. The nipple was retracted quite out of sight, and an area surrounding it of about two square inches was ulcerated, and was the cause of frequent hemorrhage. The skin was drawn in and adherent nearly all over the tumor. Movement upon pectoral muscles was very limited. No enlarged glands detected in axilla. On the evening of May 17, 1890, the tumor was well painted over with blistering fluid, and the patient was given a one-grain opium pill. On the morning of the 18th the epidermis over the blistered area was easily removed, leaving a raw absorbing surface, over this a small quantity of the hydrochlorate of cocaine was applied. This surface absorbs cocaine so rapidly that I have seen on several occasions constitutional symptoms produced within two or three minutes after its application. It is therefore necessary to be very cautious about the quantity that is applied. I think it hardly safe to use more than a grain to a grain and a half. At the same time one sixth of a grain of morphia was injected hypodermically. After waiting about ten minutes for the cocaine to become absorbed, a cake of the paste, freshly made, about an inch thick, and sufficiently large to cover the whole of the tumor, was applied. It usually takes from ten to twenty minutes for the Michel paste to destroy the skin, and during this time the patient suffers intense pain unless cocaine is used. This pain also ensues with any other escharotic. In this case, however, the patient absolutely did not feel it, and by the time the local effect of the cocaine was passing off the skin had been destroyed, and the hypodermic injection was beginning to have its proper effect. The patient was happy and comfortable and quite free from pain throughout the day, and on two or three occasions dozed off to sleep for a few minutes. The paste was applied at 10.30 A.M., and the tumor, which was found to extend considerably into the pectoral muscles, was completely destroyed by 5.30 P.M. without the loss of a single drop of blood. The cavity was cleaned out and filled with asbestos, covered over with lint and zinc ointment, and then left for the night. The patient slept well that night, sat up next day, and has since recovered remarkably well. She has had no rise of temperature. Her appetite and general health have been quite unaffected throughout.

It usually takes about twelve days for the eschar to separate, and during the latter part of this time the wound should be well syringed twice a day with a weak solution of permanganate of potash or some other disinfectant, dusted over with iodoform, and poulticed. When the eschar does separate, it leaves a healthy granulating surface, which heals up rapidly. In applying the paste, great care must be taken to place the patient in such a position, by means of pillows and supports, that the tumor is exactly level; otherwise the acid of the paste will gravitate to the lower side and destroy that portion only, leaving the bulk of the tumor untouched. Owing to the rapidity with which the acid absorbs moisture from the tissues and from the air, an oozing of fluid takes place all round the paste within a short time of its application, and this must be most carefully sopped up as it exudes with small pieces of blotting-

paper or fine linen, otherwise it will run over the surrounding skin and cause unnecessary pain, and to guard against any accident of this kind the skin around should be painted over with collodion. The position of the patient and the sopping up of this fluid are so important that only the most intelligent and reliable nurses can be trusted to watch the case. By removing the paste and cleaning out the cavity, it is quite easy to see at any time how the operation is progressing; and if any doubt exists about the nature of the tumor the diagnosis may be confirmed. The complete destruction of the tumor may be accurately ascertained in a similar way. In doing this it is necessary to avoid rash interference so as to escape injury to the large arteries often found in the neighborhood, and it is always prudent to have a few artery forceps at hand. No hemorrhage will occur unless after some interference, and in such event the artery must be ligatured; or, better, the forceps left on under the paste and the operation proceeded with as before. It is impossible to make it positively certain that the process in all cases can be completed in so short a time, or that it will be quite so devoid of pain as it was in this instance; but with proper care this should represent a fair type of the majority of such operations.

The time is too short and the number of these operations too small to be of any statistical value at present. So far, however, there is no recurrence in any, except in one of the parotid cases. This was the case of a poor man who had been previously treated for the same disease at Guy's Hospital. He had there undergone two operations within a few weeks, the second being for a recurrence. I removed a second recurrence on April 2, 1889, and he went on well for six or eight months. When last seen, however, he was in a very bad state. The remaining twenty-nine were tumors of the breast, one of which I have not seen or heard of since. I therefore think it best to leave it out of the calculation, thus bringing the total number of breast patients to twenty-eight. Two had tumors in both breasts, and in each case the whole of both glands had to be removed. Two had recurrences, and a second operation was in both cases necessary, making the number of operations thirty-two. Out of this number twelve were treated from eighteen months to over two years ago, and seven of the patients are now free from a recurrence, including one who had both breasts removed. One has a local recurrence at the present time; one died of secondary deposit in the liver; one of tetanus, eight months after operation for recurrence; one from chronic bronchitis and asthma; and one from acute bronchitis. The last two were attended by other medical men. I had, however, suspected some malignant mischief of lungs in both cases some time previously. Ten patients were treated from twelve to eighteen months ago. Seven are now free from recurrence, including one who had both breasts removed. One was a palliative operation only and the patient's health has been much better since; two died of cancer of the liver and distant glands. There were no local recurrences in any of these. The six cases treated during the last twelve months are free up to the present time. I might mention that in all the twenty-eight cases the malignant nature of the disease was almost as certain as in those particularly described, and the diagnosis was verified in nearly every case by other surgeons.

Escharotics have many disadvantages as well as some advantages, and these should be carefully weighed, having regard to the nature of the tumor, its position, the general health and age of the patient, etc., before advising any particular treatment. I have endeavored throughout to avoid any partiality, and I by no means share the extravagant views of most of those who have been in the habit of using escharotics. I think, however, that the immunity from recurrence so often claimed by these enthusiasts deserves a more careful study than it has hitherto received from careful observers. Judging from my own cases, even after making a very liberal allowance for errors in diagnosis, the small number of local recurrences is very remarkable, while there is no such marked absence of secondary deposits in distant organs. If we admit that there is a difference in this respect, the natural question is, What is the explanation? My answer is that I do not know, but with caution and reservation I venture to suggest the following: 1. It is well known that local recurrences after knife operations nearly always begin as small, hard, and well-defined nodules on the very edge of the scar, being partly in the normal and partly in the cicatricial tissue. Attention has been drawn to this

fact recently by a number of our most eminent surgeons, and they suggest that the operation should be of a more sweeping character. 2. It is also highly probable that cancer can be inoculated. 3. Is it not equally true that surgeons seldom complete the removal of malignant tumors before the operating knife cuts into some portion of it, and that therefore the blade of the knife must get covered with cancer cells, juice, germs, or whatever the substance may be that inoculates? Completing the operation with the same blade, it is easy to conceive that some of the inoculating material would be left imbedded in the healthy tissue, in spite of careful antiseptic washing, and the wound closed up with all the original tumor most carefully removed, but with the germ of the recurrent disease unintentionally as carefully sown in good soil.—*Lancet*, Oct. 25, 1890.

A Visible Heart.—There is at the present time in St. Mary's Hospital a child about a fortnight old, in whom the sternum and costal cartilages are imperfectly developed. The heart is seen most distinctly through the thin cutaneous wall of the chest. The shape and size of the auricles and ventricles, with the filling of the auricles with blood, are quite as visible for all practical purposes as if the organ were completely exposed to view.—*Med. Press*, Oct. 29, 1890.

Bissell (J. B.) on Some Objections to Cocaine in Genito-Urinary Surgery.—The author claims that when internal urethrotomy is done under cocaine, shreds of urethral mucous membrane are often brought away between the blades of the urethrotome. Endoscopic examinations have taught him that, after anæsthetization with cocaine, the urethral mucous membrane is bluish and congested, and in this way the lumen of the canal is lessened. This effect is more marked in pathological (strictured) urethræ.

Urethral hemorrhage is more common after urethrotomy performed under cocaine than that under ether or chloroform.

In circumcision the cocaine injection often obscures the edges of the cut and leaves a ragged and irregular line of union. The extravasation of blood following the use of cocaine is objectionable and may give rise to sloughing.

The sight of the operation, instruments, etc., is objectionable in nervous patients and children.—*Med. Record*, Nov. 1, 1890.

Davis (T. G.) on the Treatment of Soft Chancres.—Twice daily the sore is washed with pure warm water; then a solution of hydrogen peroxide is dropped upon it until bubbles of gas cease. The sore is then dried with absorbent cotton and dusted with a powder composed as follows:

℞ Bismuth subnitrate.
Powd. yellow cinchona . . āā 3 ii.
Calomel . . . . . 3 i. m

This is painless and odorless, and has proved entirely satisfactory to patients and to myself during the past four years.—*Med. Record*, Nov. 1, 1890.

Reichert (E. T.) on the Action of Alcohol on Animal Heat Functions.—The results from seventeen elaborate experiments by the author show clearly that alcohol does not affect the total quantity of heat produced; that more heat is dissipated than produced; that the fall of temperature is due to the excess of dissipation and is in direct proportion; and that in all likelihood alcohol, by undergoing oxidation, yields energy in the form of heat, thus conserving the tissues and acting as a food.—*Therap. Gaz.*, Feb. 15, 1890.

BOOK NOTICES.

Massage: A Primer for Nurses.—By Sarah E. Post, M.D. (Lecturer before the Training Schools for Nurses connected with Bellevue Hospital, Mt. Sinai Hospital, and St. Luke's Hospital, New York, and the Memorial Hospital, Orange, N. J.). New York: The Nightingale Publishing Company, 13 West 42d St., 1890.

This little volume of about fifty pages contains in concise form and explicit language all that the ordinary trained nurse needs to know about massage. It should be in the hands of every nurse, and even general practitioners of medicine will find it to their advantage to familiarize themselves with its valuable contents. F. P.

A Treatise on Headache and Neuralgia, Including Spinal Irritation, and a Disquisition on Normal and Morbid Sleep. By J. Leonard Corning, M.A., M.D. With an appendix: **Eye-Strain, a Cause of Headache**, by David Webster, M.D. Illustrated. Second edition. New York: E. B. Treat, 5 Cooper Union. 1890. Price, $2.75.

This volume of Dr. Corning's is now in its second edition, and is enlarged by the addition of the appendix on Eye-Strain and Headache, by Dr. Webster. The general nature of the work is so well known as to hardly require comment here. It includes many of Dr. Corning's original and valuable procedures for the treatment of functional nervous diseases, and will well repay perusal.

F. P.

THE MEDICAL ANALECTIC AND EPITOME.

A MONTHLY RETROSPECT OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE.

EDITED BY R. W. AMIDON, M.D.

VOL. VII., No. 12. December, 1890. WHOLE No. 164.

LEADING ARTICLE.

The New Treatment of Tuberculosis.—Knowing full well that the readers of the ANALECTIC AND EPITOME will expect to see something in the present number on the subject now agitating the public press and advertising doctors, the editor considers a word of explanation necessary.

While not underrating the scientific eminence of the discoverer of this remedy, nor presuming to condemn the method of treatment unheard, the editor claims that, until Koch takes the medical brotherhood into his confidence and divulges the exact nature and composition of his remedy, it cannot be scientifically discussed, nor should its bare existence be seriously entertained by self-respecting physicians.

Until this confidence and evidence of good faith is extended, the editor sees no good reason for departing from his former invariable custom of utterly ignoring, unless to condemn, secret preparations. As to the doctors who are falling over each other in the scramble for newspaper notoriety, we see no difference between the ones using the genuine "lymph" (so-called), or those who, interpreting more broadly the motto "the end justifies the means," float to newspaper fame on hydrocele fluid.

The old saying goes, "no matter what the vessel is so the wine in it be good." What then if the "vessel" be the *tunica vaginalis* and the "wine" the limpid nectar exuding from some puckered "Thespian" testicle?

Suppose the characteristic symptoms detailed by Koch do not appear after injection of this fluid, but only a mild erotic inclination to go on the stage? The end is attained. Glaring headlines announce that the celebrated Doctor Blank, at the Mt Pisgah Hospital, first of all Americans (Heaven forgive the misnomer), subcutaneously instilled the far-fetched Teutonic virus. For the present let us not dream nor rave, but quietly await results, saying to ourselves that perhaps "it will but skin and film the ulcerous place, whiles rank corruption mining all within infects unseen."

SOME RECENT FOREIGN CONTRIBUTIONS TO THE STUDY OF REFLEX NEUROSES.

Coupard and St. Hilaire—Contributions to the Study of Headaches, Neuralgias, and Migraines of Nasal Origin.—This paper is based on a series of cases of neuralgia, headache and migraine of from one to twenty years' standing, cured by the intra-nasal use of cocaine, the cautery, or more surgical procedures.

The following cases are of the most interest:

1. Cauterization of the lower turbinated body was followed by frontal and occipital pain. The part cauterized was touched by cocaine solution, and complete relief followed.

2. A man insufflated a strong solution of borate of soda, and was at once seized with violent right orbital and occipital pain, lasting some minutes and disappearing of its own accord.

3. A man of twenty-eight had hypertrophy of the nasal mucous membrane. The posterior part of the right inferior turbinated body was cauterized. For two days patient suffered with right hemicrania.

4. A migraine of the left side was cured

by cauterization of the hypertrophied left turbinated body.

5. A woman of twenty-six had application of galvano-cautery to turbinated bones of both sides. The next day, had very severe supra-orbital neuralgia, so acute that she could n't open or shut eye. The right nostril was flushed with cocaine solution, with immediate and permanent relief of pain.

6. Male of forty-four, neuralgia of twenty years' standing. Intense pain in the course of the supra- and infra-orbital nerves, and at one time in the inferior maxillary nerve. After failure of all ordinary treatment a cure was effected by simple cauterization of the hypertrophied middle turbinated body.

7. Physician, twenty-four, migraine of twelve years' standing. Hypertrophy of turbinated bodies. Migraine cured by local applications of cocaine solution.

8. Male, forty-five. Migraine three years' standing. Cured by removal of nasal polypi.

9. Woman, twenty-eight. Migraine sixteen years. Cured by nasal cauterization. (Hypertrophied turbinated bodies.)

10. Woman, thirty. Migraine six years. Cured by cocaine næsthesia of turbinated bodies.—*Tribune Méd.*, Feb. 20, 1890, *et seq.*

Ponce (G.) on Paralysis of the Right External Rectus Muscle in a Patient with Chronic Otitis.—A child, after a fall on the occiput, developed a paralysis of the right external rectus muscle. According to the author, this paralysis was evidently not of traumatic origin, as recovery took place only after treatment of an otitis, of which the patient also complained.—*La France Méd.*, Jan. 10, 1890.

Ponce (G.) on Intense Photophobia Cured by Direct (?) Anæsthesia of the Gasserian Ganglion.—A child of thirteen was attacked in August with a phlyctenular keratitis. In November the other eye was similarly attacked. When any attempt was made to open the eye to examine the cornea, the patient sneezed violently—a fact pointing to the well-known cilio-nasal reflex. The corneæ were very vascular and there was much photophobia.

To anæsthetize the Gasserian ganglion the author introduced into the right external auditory meatus a pellet of cotton saturated with chloroform, and he was then able to open the right lids without making the patient sneeze. The patient still sneezed when the left eyelids were opened, but more tardily and less violently than before. The foregoing treatment daily applied in both ears caused the photophobia to disappear little by little.—*La France Méd.*, Feb. 7, 1890.

Joal on Certain Symptoms of the Menopause of Genito-Nasal Origin.—The author has observed certain cases of hypertrophic rhinitis which seem to depend upon circulatory disturbances having their origin in the genital apparatus. He has traced the same connections between the genital apparatus and the epistaxis and headache of puberty.

The excitement coincident with the menopause provokes turgescence of the nasal mucous membrane, and causes neuropathies consecutive to erection of the cavernous bodies.

In four cases the author has, by the intra-nasal use of cocaine or the actual cautery, given immediate relief or prevented future recurrence.—*Four. de Méd. et de Chir. Prat.*, Feb., 1890.

MEDICINE AND PATHOLOGY.

Nothing New under the Sun.—It is curious to find that something like the present-day theories of a struggle between the microbes and leucocytes must have been in vogue more than a century ago, otherwise this bit of satirical burlesque could scarcely have been written and played :

Persons—The Devil as Hellebore, President of the College ; Dr. Last, a new Licentiate ; other Doctors and Pupils.

Hel. . . . Proceed we now to the lecture ! Brethren and students, I am going to open to you some notable discoveries that I have made respecting the source or primary cause of all distempers incidental to the human machine. And these, brethren, I attribute to certain animalculæ of piscatory entities, that insinuate themselves through the pores into the blood, and in that fluid sport, toss, and tumble about, like mackerel or cod-fish in the great deep. And to convince you that this is not a mere *gratis dictum*, an hypothesis only, I will give you demonstrative proof. Bring hither the microscope !

Enter a SERVANT *with a microscope.* Doctor Last, regard this receiver. Take a peep.

Last.—Where?

Hel.—There. Those two yellow drops there were drawn from a subject afflicted with the jaundice.——Well, what d' ye see?

Last.—Some little creatures like yellow flies, that are hopping and skipping about.

Hel.—Right. Those yellow flies give the tinge to the skin, and undoubtedly cause the disease. And now for the cure! I administer to every patient the two-and-fiftieth part of a scruple of the ovaria or eggs of the spider; these are thrown by the digestive powers into the secretory, there separated from the alimentary, and then precipitated into the circulatory, where, finding a proper nidus or nest, they quit their torpid state, and vivify; and upon vivification, discerning the flies, their natural food, they immediately fall foul of them, extirpate the race out of the blood, and restore the patient to health.

Last.—And what becomes of the spiders?

Hel.—Oh, they die, you know, for want of nutrition. Then I send the patient down to Brighthelmston, and a couple of dips in the salt water washes the cobwebs entirely out of the blood.—From Foote's "Devil on Two Sticks," in *Edinburgh Med. Jour.*, Dec., 1890.

The Survival of the Fittest (Bacillus).—Professor V. de Graxa is stated by the *Journal of the Royal Microscopical Society* to have discovered that cholera can only develop to the full extent when the soil happens to be unusually free from ordinary bacteria, inasmuch as the cholera germ, being weak and delicate, is eaten up by the more active and hardy sorts of microbes. This discovery, if true, opens a vista of speculation for the sanitarian faddists. Query, Have we not been promoting invasions of cholera morbus all this time by killing off the usual bacterion? Would it not be well in future to propagate in gelatine or chicken broth the hardy and voracious species, and to sow the soil with them as a defensive measure against the cholera morbus?—*Med. Press*, Nov. 19, 1890.

Birchmore (W. H.) on the Mycology of Urethritis.—The author has been studying this subject since 1875. Besides the Neisser coccus he in a number of cases found also a bacillus which, by reason of its shape, became known to its intimates as the bacillus fabiformis. This bacillus is, he thinks, distinctly a saprophyte, and he believes is to be found in nearly all instances of pus retained within the vagina, and in nearly all cases of catarrhal degeneration of the epithelium of the glans *in situ*.

In his article the author tabulates thirty-one cases in which the discharges have been examined by himself. Of this table the following is a summary:

Total number of cases	31
" " " men	17
" " " women	8
" " " boys	3
" " " girls	3
Incubation	4.3 days.
Duration to commencement of treatment	9.0 days.
Duration of treatment	21.0 days.
Duration after treatment	19.0 days.
Total average	53.3
Neisser's coccus found	16 times.
Bacillus fabiformis	14 times.
Suppuration cocci	13 times.
Neisser and bacillus	1 time.
Neisser and coccus	9 times.
Bacillus and coccus	3 times.
Neisser's coccus alone	6 times.
Bacillus fabiformis alone	10 times.
Suppuration cocci alone	2 times.
All three	1 time.

—*Kansas City Med. Index*, Oct., 1890.

Francotte (X.) on Restoration of the Functions of the Hind Limbs in Two Dogs after Total Section of the Cord in the Lower Dorsal Region.—The immediate result of section is, of course, a complete paralysis of sensation and motion in the posterior half of the body, with incontinence of urine and fæces. The cutaneous, anal, and patellar reflexes are preserved.

In the course of a month, marked trophic disturbances take place in the paralyzed parts; they emaciate, ulcers (bed-sores) form, and the hair turns rusty and falls out. These trophic changes, after reaching a maximum, gradually improve, and about two months after the operation slight signs of returning motility appear. Instead of dragging the hind legs after him or under him, the animal begins to stand upon all fours, and later really shows in his walk that he has some voluntary control over their movements. Of course the hind legs are tremulous and weak, and after a certain time give way, but the movements, whether the animals stand or are held on the back, are such as to preclude the possibility of their being reflex in their origin.

All reflexes in the hind quarters are exaggerated. There is little or no return of sensibility. The limbs regain some of their lost flesh. Involuntary evacuations continue.

An examination of the cord by means of transverse sections through the cicatrized portion of the cord shows connective tissue, scattered through which are here and there nerve fibres, either isolated or collected in bundles.—*Annales de la Soc. Méd.-Chir. de Liége*, Nov., 1889.

Bullard (W. N.) on Diffuse Cortical Sclerosis of the Brain in Children.—The author describes a form of diffuse cerebral sclerosis in children in which the cortical layers of the brain are more especially affected, and which is clinically distinguished from the other forms by its appearance in healthy children, either without known cause, or after traumata, by the steadily progressive character of its symptoms, and by the especial prominence of the gradually increasing dementia, which finally reaches an extreme degree without a corresponding loss of motor power, and while the sensation is comparatively unaffected. The pathological condition found is pathologically undistinguishable from that found in adults in general paralysis.—*Jour. of Nerv. and Ment. Dis.*, Nov., 1890.

Médiné, (of Stockholm), on an Epidemic of Infantile Paralysis.—During the months from May to November, 1887, the author observed an epidemic of infantile paralysis more important than the epidemic reported by Cordier at Lyons. During these months 42 cases were observed, among which 15 were in August and 17 in September. The author concludes that the disease is infectious.—*Jour. de Méd. et de Chir. Pratiques*, Oct., 1890.

Dumas on a Case of Facial Erysipelas from Accidental Inoculation with the Muco-Pus of Endometritis.—The patient, a childless married woman of 28 and a sufferer from endometritis, touched some cotton which had been used to wipe off the muco-pus from her own cervix, and afterwards, without having washed her hands, scratched a slight itching eruption on her face (due to heat). The next day the patient complained of general malaise and chilliness, and on the fifth day showed a fully developed facial erysipelas, which run a course of unusual severity, but terminated in recovery.—*Gaz. Hebd. des Sci. Méd. de Montpellier*, Nov. 23, 1890.

Menzies (J.) on the Connection of Acute Pneumonia with External Injury.—A man of fifty fell from a height of several feet whilst unloading a cart of hay, his left side coming into violent contact with the projecting shaft, causing a contusion of the thorax over the lower pulmonary area, but no ribs were broken. He was confined to bed with symptoms of concussion, from which he soon recovered, but four days later he complained of severe pain in the side injured, with high temperature, hurried respiration, and cough, my diagnosis being confirmed on the sixth day by the presence of the usual physical signs incident to pneumonia. The case went on to a satisfactory termination in three weeks, and as the patient was in perfect health prior to the injury, must have been purely traumatic in character.—*Brit. Med Jour.*, Nov. 22, 1890.

Isdell (F.) on Concussion of the Lungs as a Cause of Pneumonia.—In 1885 I attended two children, of different families, at an interval of about a week. They were boys, aged about seven and nine years. They both suffered from pneumonia of one lung, presenting the usual symptoms, and the history of the cases was strangely identical. They were described to me as having been in the best of health two or three days before, when, in the course of play, they both received falls on the pavement, sufficiently severe to stop their play and make them go home and tell their parents. Within at any rate twelve hours they were seized with feverishness, etc. In both cases the pneumonia was well marked, but not severe.—*Brit. Med. Jour.*, Nov. 8, 1890.

Gwynne on an Epidemic of Pneumonia.—This epidemic occurred in Sheffield in the first half of the current year. The following are the distinctive features of the epidemic as derived from a review of numerous cases that came under the author's care: 1. The tendency in the case of many individuals attacked by influenza for a slight patch of pneumonia to appear suddenly, generally at the base of a lung, with very slight rise of temperature, and almost as suddenly to disappear. 2. The common occurrence of blood-colored sputum. 3. The weak asthenic type of the disease that was prevalent, many cases being subacute from the first, and the convalescence tedious; and many more assuming from the very commencement a

typhoid character, the patient in many instances dying from the fourth to the seventh day of the disease, 4. The tendency to unusual complications, illustrated by cases where relapses, parotiditis, phlebitis, pericarditis, and abscess of the lung supervened. 5. In some instances the attack could be traced to distinct infection. 6. The marked immunity that children enjoyed.—*Med. Press*, Oct. 29, 1890.

Combemale on Sudden Death in Asthma.—A man of forty died suddenly in the hospital, to which he had been admitted fifteen days before for continued dyspnœa, cardiac palpitation, and uncontrollable vomiting. These disturbances, while they rarely were all present on one day, gave the patient little rest, and seemed to the author to be due to a disturbance of the pneumogastric nerves or centres. The vomiting yielded to an effervescing draught, the dyspnœa was relieved by some cups and aconite. At the same time the painful tachycardia disappeared.

Two days later severe asthmatic symptoms set in, which persisted for four days in spite of heroic dosing with bromides, iodides, and inhalations of datura fumes. A thorough physical examination did not reveal the cause of the asthma, and the patient died suddenly at the close of an attack.

At the autopsy there were found numerous old adhesions at the sides and backs of the lungs. The lungs were congested and œdematous, the bronchi the same. At the apex of the right lung was a calcareous nodule, while at the apex of the left was an emphysematous patch, while similar areas were scattered over the anterior surface of both lungs. The heart was rather small and externally surcharged with fat. Its color and consistence were normal, but the left ventricle was rather thin. The sigmoid valves of the aorta were sprinkled with fine patches of atheroma along their free border, and were slightly rigid. The aortic valve was slightly insufficient to the water test. The aorta had patches of fatty atheroma.

There were no gross changes in the abdominal or cranial cavity.

The lesion which, in the author's opinion, probably had most to do with the symptoms was that of chronic tracheitis.—*Bull. Méd. du Nord*, Sept. 26, 1890.

Upshur on Convulsions Following the Ingestion of Unsound Oysters.—The patient was a woman of usually robust health. He had found her with decided trismus—spasmodic contraction of both flexor and extensor muscles of hands and of the lower extremities; spasms, both violent and painful, lasting several minutes, and excited by a slight draft or current of air. There had been no wound to give origin to suspicion of traumatic tetanus, and no probability of her having obtained strychnine. But it seemed she had eaten a few raw oysters the day before, when the weather was warm. The convulsions had been accompanied by choleraic symptoms—nausea, vomiting, and purging, but no collapse. He had administered morphine hypodermically and chloroform by inhalation, and had further controlled them by twenty-grain doses of bromide of potassium every two hours. He was satisfied that the convulsions were due to eating unsound oysters.—*N. Y. Med. Jour.*, Nov. 22, 1890.

Meigs (A. V.) on the Morbid Anatomy of Typhoid Fever.—According to the author the disease is a general one, involving a large part of the system, and in no way a local disease of the intestine. This belief is supported by the many and extensive organic lesions found in the body after death; and thus it would seem likely that Harley is right in his statement that the disease is due in the first place to derangements of function, and in rejecting the germ-theory of its origin.

The frequency of hemorrhages in various parts of the body and their importance, I dwell upon and I wish to state my belief that hemorrhage into the substance of the lung is most common. This latter, if not a new observation, is a fact certainly not commonly known.

The observation that the spleen, mesenteric glands, and lymphoid tissue of the ileum are made up to a great extent of large multinucleated cells instead of the ordinary small lymphoid elements is a curious and interesting one and requires further study; such study may possibly lead in the future to something which may have practical value.

Careful microscopical study of the condition of the spinal cord in the disease is much to be desired.

There should be a careful consideration of the previous condition of bodily perfection of persons attacked by the disease as having an important bearing upon prognosis.

We should be influenced in our treatment of typhoid fever to a great degree by the manner in which it takes violent hold of this or that portion of the organism. Our therapeutic efforts will be much more likely to be crowned with success by a careful consideration of this matter.—*Med. News*, Nov. 15, 1890.

Rueteneyer (L.) on Ehrlich's "Diazo" Test in Typhoid Fever.—As is well known, the test requires a solution of sulpho-diasobenzol, which is prepared by mixing 200 cubic centimetres of a concentrated aqueous solution of sulphanilic acid, with 10 cubic centimetres of pure nitric acid and 6 cubic centimetres of 0.5 per cent. solution of chemically pure nitrite of sodium. As Professor Ehrlich first showed, a typhoid patient's urine, on being made strongly alkaline by ammonia, and then mixed with an equal part of the test solution, assumes a red color, varying from light-rose to dark-carmine red. After standing from twelve to twenty-four hours, the mixture deposits a sediment, the upper stratum of which shows a light or dark green, or violet-blackish coloration (according to the intensity of the reaction)—that is, according to the quantity of an anomalous red pigment body present in the urine. Having tried the reaction 2,750 times in 260 patients suffering from various diseases (1,130 times in 87 typhoid cases), the author has arrived at the following conclusions: 1. The diazo test has a very high diagnostic value in regard to typhoid fever. In fact, in common with enlargement of the spleen and the characteristic rash, the reaction constitutes one of the earliest and most constant signs of the disease. 2. Febrile abdominal catarrhs never show the reaction. 3. There is not, however, any hard and fast correlation between the reaction and the course of the pyrexia. 4. Morning and evening urine gives reaction of equal intensity. 5. The treatment by baths and antipyretic remedies (thallin, etc.) does not interfere with the test. 6. Speaking generally, the disappearance of the reaction on a second or third week of the disease points to approaching apyrexia and a mild course of disease, while a more prolonged persistence of it makes it probable that the disease will run a more or less protracted or severe course. 7. Relapses are almost invariably accompanied by the reappearance of the reaction. —*Brit. Med. Jour.*, Aug. 30. 1890.

Righter (W. H.) on Chancre of the Ear.—In August, 1882, a man consulted me with his own diagnosis of "mumps." He had an enlargement of the left parotid gland, resembling mumps. He, with a friend, spent three weeks together on a drunk in a neighboring city, and while they were drinking, embracing each other and telegraph poles, and smoking cigars, this person received a burn upon his left auricle; a good Samaritan came along, licked a piece of court-plaster, and placed it upon the burn. I found a sore upon the left auricle, which I diagnosed a chancre, with bubo of the parotid gland.

I instructed the patient to observe his skin from that time on. In about three weeks from my first observation he returned with a syphilitic roseola, and still the patient refused to accept my diagnosis.

In October of the same year he visited my office, with the loss of hair, moustache, eyebrows, and his mouth was full of the secondary lesions of syphilis. He took my advice, became well apparently, moved to Kansas City, where he now lives, and never has felt grateful enough to the doctor to settle his bill.—*Kansas Med. Jour.*, Sept., 1890.

Lockwood (G.R.) on Purpura Hemorrhagica.—From the following conclusions it appears that the author is inclined to consider purpura hemorrhagica or Werlhof's disease and some kindred diseases of bacillary origin:

(1) Werlhof's disease was probably infectious in origin, the exact agent of infection not having been absolutely proved, though it might be the bacillus described by Letzerich.

(2) There were acute cases of this infection in which death resulted from acute anæmia, from internal hemorrhage, or from sepsis.

(3) Purpura simplex and purpura rheumatica were probably types of different grades of the same infection, and this infection might be the same as that of Werlhof's disease.

(4) Scurvy, if proved an infectious disease, might be really Werlhof's disease modified by the surroundings and poor condition of the patient, and also by the possibility of the infection being more chronic.

(5) Drug purpura, anæmic and cachectic purpuras, purpuras in exanthemata and other infectious diseases, purpuras in the

newly born, in endocarditis and multiple sarcomata, as well as those of neural origin, might present all grades of severity; one could in each determine a cause, though it was not possible to know exactly how the symptoms were produced by this cause, whether by blood changes or vessel changes or from nervous causes, but these purpuras were symptomatic and not essential, and should not be classed with purpura hemorrhagica or Werlhof's disease until there was more definite information on the subject.—*N. Y. Med. Jour.*, Nov. 15, 1890.

Van Santvoord (R.) on Spontaneous (Non-Instrumental) Access of Bacteria to the Bladder and Slight Vesical Incompetence as Causes of Cystitis, Especially in the Female, with Remarks on Treatment of the Resulting Disease.—The writer reviews the literature of spontaneous bacteriuria, *i. e.*, of cases in which, in the absence of specific disease, bacteria for the most part indistinguishable by ordinary microscopic examination from those usually found in decomposing urine were present in freely passed urine. Stress was laid especially on a paper read by Dr. Wm. Roberts before the International Medical Congress in 1881, in which he distinguished between two forms of spontaneous bacteriuria, in one of which the urine settled clear after being passed; in the other it remained turbid, resembling urine undergoing decomposition. In the former the symptoms of vesical disease were cured or greatly relieved by salicylate of soda, the bacteria disappearing entirely or almost entirely with the relief of symptoms. In the second class no effect was produced on symptoms of bacteriuria by the same drug.

The writer of the paper cited cases from his own experience illustrating these two forms of disease, and confirming Dr. Roberts' conclusions as to the effects of the salicylates.

In two cases of the second form of the disease it was pointed out that for months before the development of acute symptoms the patients complain—in one case of foul-smelling urine and slight vesical irritability; in the other, of slowness and effort in the act, the urine being turbid on being passed. Slight vesical atony, spontaneous invasion of the bladder by bacteria, whose multiplication in that organ was rendered possible by the residual urine, and final transformation of slight irritation into an acute inflammation under the influence of apparently trifling exposure, seemed to be the most rational explanation of the clinical course of these cases.

The treatment consisted, first, in doing away with the vesical atony by the use of strychnine and cantharides, and possibly electricity. The tenesmus attending acute symptoms might in itself be a useful factor in stimulating vesical contraction. It should not be entirely suppressed by too free use of narcotics, nor should large vesical injections be used for the same reason. The bacteria would vanish when the bladder became able to fully empty itself, and when the products of inflammation which furnished appropriate nourishment for them ceased to be formed under the influence of appropriate treatment. Injections of antiseptics, strong enough to be bacteriacidal, were too irritating. All the bacteria were not reached, and the inflammation was aggravated by them.

The cases cited were probably common varieties of disease. The existence of slight vesical atony might be difficult to demonstrate in the female, and was probably more frequent than the current literature would lead one to expect. The recognition of bacteriuria, especially of the second variety treated by Dr. Roberts, was of value as pointing with great probability to this condition.—*Times and Register*, Nov. 15, 1890.

THERAPEUTICS.

Jewett (C.) on the Comparative Value of the Biniodide and the Bichloride of Mercury as Surgical Antiseptics.—The author states that biniodide of mercury was less toxic than the bichloride, if used in proper concentration, it was as potent as a germicide; it is a more stable chemical compound; it is more agreeable to the operator. Experiments made at the Hoagland Laboratory gave the following conclusions:

1. In equal concentration, the biniodide was slightly inferior to the bichloride in germicidal power. 2. For equal potency as a sterilizing agent, the biniodide should be used in greater concentration than the bichloride—say 1 to 1,800. 3. The difference in the efficacy of a 1-to-2,000 solution of bichloride and a 1-to-1,000

solution was insignificant. 4. The activity of a 1-to-2,000 solution of biniodide was materially greater than that of a 1-to-4,000 solution. Alcohol should be used before the sterilizing solution, for its hygroscopic action.—*N. Y. Med. Jour.*, Nov. 15, 1890.

Lemoine on the Toxic Action of Boric Acid.—The author narrates three cases, the first, one of his own, and two, those of Dr. Vincent, of Armentières.

CASE 1.—A woman of thirty-six, a victim of general paralysis, had an arterio-sclerosis characterized particularly by an interstitial nephritis with slightly albuminous urine and a blowing heart murmur. She had two sloughing bed-sores, one a large one over the right trochanter, which, not yielding to ordinary treatment, was sprinkled every morning with a powder composed of equal parts of boric acid and powdered quinquina. Under this treatment the sores took on a better aspect, but in five days a rubeola-like eruption invaded the trunk, particularly the dorsal region, and later nearly the entire body.

This eruption resembled that of confluent rubeola, only the macules were a much more vivid red. Confluent on the back and sides the eruption became more scattered on the rest of the trunk and discrete on the limbs.

There was no fever nor acceleration of the pulse, but there was continuous nausea, repeated vomiting, intense headache, and insomnia. Active delirium supervened, characterized by loquacity, hallucinations of sight and general sensibility, night-terrors, etc. The treatment was changed to carbolic irrigations and a powder of charcoal and quinquina, with relief of symptoms.

To assure himself of the true cause of the symptoms, the author after a while reinstituted the same treatment, with the result of bringing back the old train of symptoms, except that the rash this time took on a hemorrhagic form and occupied chiefly the abdominal region.

CASE 2.—In a patient with empyema, the pleural cavity was repeatedly washed out with a four-per-cent. boric-acid solution. Some fluid was evidently retained and gave rise to the following symptoms: general urticaria, delirium with incoherence, and some vomiting. No fever.

CASE 3.—Irrigation of a bladder, from which a myxomatous tumor had been removed, with a four-per-cent. solution of boric acid, produced symptoms similar to those of Case 2, except there was no urticaria nor vomiting.

The author quotes Johnson, of Stockholm, as having observed cases of boracic-acid poisoning in which the symptoms were headache, vomiting, slight acceleration of the pulse, slight elevation of the temperature, redness of the throat, bronchial catarrh, and papular erythema.

Polli is cited as having seen a soldier swallow by mistake six drachms, without bad effect, while Capelli has given a man a drachm a day for twenty-three days, and half a drachm a day for forty-five days, without any disagreeable symptoms.

Guyon and G. de Mussy have given without harm thirty to forty-five grains daily to disinfect the bladder in old men.

Thirty to sixty grains have been injected into the veins of dogs without appreciable symptoms, while in doses of five drachms it only excites nausea and vomiting. It is eliminated by the kidneys, but has been found in the blood of the portal vein, the bile, and saliva.

It is altogether probable that toxic effects are more likely to be produced in patients suffering from renal inadequacy or disease of the urinary tract lower down. —*Bul. Méd. du Nord*, May 23, 1890.

Bryce (T. H.) on the Value of Hydronaphthol as an Antiseptic.—Hydronaphthol is a derivative of β-naphthol, and is a whitish powder of fine, flaky crystals, very insoluble in water, freely soluble in alcohol. Its insolubility in water stood in the way of experimentation, but the author hit upon a solution,

Hydronaphthol	1 part	1 part,
Rectified spirit	10 parts	
Glycerine		9 parts,

which prevented precipitation in water: making a brown solution of 1 to 100; and with this he was able to get a clear and permanent solution of any strength.

The experiments were conducted upon the staphylococcus aureus and with pus from septic cases.

It is found to be germicidal in the strength of 1 to 400, and antiseptic in still weaker solutions.

A great drawback to its use in surgery will be its insolubility in water.—*Brit. Med. Jour.*, Nov. 22, 1890.

Dysentery Caused by Calomel Injections.—The hypodermic or intra-muscular injection of calomel suspended in

oil, which is a form of treating syphilis much more practised abroad than in this country, is not without occasional inconveniences; thus Dr. Cramer reported a short time since a case where, after six injections at intervals of a week, a patient became the subject of a severe dysentery. This accident was not due apparently so much to any idiosyncrasy of the patient as to the fact that he had been secretly dosing himself with iodide of potassium, which permitted a large quantity of mercury to collect in his tissues.—*Lancet*, Nov. 29, 1890.

Allingham (L. W.) on Gangrene Checked by Immersing the Limb in Alcohol.—The author narrates three cases in which an advancing gangrene was apparently checked by immersing the part in alcohol kept warm by means of a coil of rubber tubing through which hot water passed. The author advances no explanation of the mode of operation of this treatment, which probably is efficacious because of its antiseptic, emollient action.—*Canada Lancet*, Dec., 1890.

Artificial Salicylic Acid. — It is claimed that prejudicial effects accompany the medicinal employment of the artificial salicylic acid prepared according to Kolbe's patent, as distinguished from the "natural" acid obtained from oil of wintergreen. About ten years ago, Dr. P. W. Latham pointed out that the administration of large doses of the artificial acid was frequently attended with serious consequences, and, therefore, recommended the exclusive use of the "natural" acid. Recently, the matter has been further investigated by Dr. Charteris, who has ascertained, by direct experiment, that the acid from the two sources differs in its physiological effects, the "natural" acid being innocuous, but the artificial acid decidedly toxic. The medical profession will, therefore, heartily welcome the results of a chemical investigation, since not only has the nature of the adventitious substances associated with the acid prepared synthetically from carbolic acid been recognized, but a method has been elaborated, by means of which these impurities may be readily and completely removed. The existence of foreign acids in salicylic acid was demonstrated in 1878 by Mr. John Williams, who isolated from the commercial product two bodies differing in their physical characters from the true acid. These bodies have been identified during the present investigation as two isomeric acids, ortho- and meta-cresotic acids, homologues of salicylic acid, whilst a third isomeride, para-cresotic acid, unaccompanied by either of the above-mentioned, has been discovered occurring to the extent of 8.10 per cent. in the artificial acid at present in the market. The value of the research has been enhanced by the collaboration of Dr. Charteris, to whom the three impurities were submitted for physiological examination, and who reports that two of them, the ortho- and para-cresotic acids, produce a toxic action upon animals. Whilst the first two bodies had been separated by Mr. J. Williams by means of the varying solubilities of the calcium salts, Professor Dunstan has based his method of purification upon the fractional crystallization from alcohol of the lead salts. Judging from the simplicity of the method of purification now proposed, no difficulty should arise in obtaining at comparatively small cost, a chemically pure commercial product, which medical men can freely administer in the treatment of disease without fear of fatal consequences. —*Brit. Med. Jour.*, Nov. 22, 1890.

Chinese Treatment of Diphtheria. —A popular remedy for diphtheria, which has been employed in China for over three hundred years, recently formed the subject of a communication by M. Lecerf to the Société de Médecine Pratique of Paris. The treatment consists of blowing a powder into the throat, using a decoction of plants as a gargle and drink, and the employment of certain hygienic measures. The powder is called *sin-seh*, and it appears to consist essentially of borax, camphor, powdered pearls, cinnabar, acetate of copper, and charcoal, the percentage of borax and camphor being respectively 42.5 and 12. From twenty to thirty centigrammes of this powder are blown through a paper tube every two hours. The decoction is diffioult to imitate, as it is made from the following: roots of the coptis teeta (Scutellaria viscidula), Panax quinquefolium or ginseng, and Platycodon grand.; flowers of Caprifolium chinense, fruit of the Uvularia cirrhosa, bark of Pterocarpus flavus, Capanus flavus root, and Glycyrrhiza glabra. About fifty grammes of each are boiled in a pint of water until it is reduced to 200 cubic centigrammes. This is filtered, allowed to cool, and given in three doses in the twenty-four hours. The regimen enjoins

the avoidance of ice, cold drinks, sugar, and fatty matters and fruits, but allows at first boiled rice, eggs, and salt fish, and later boiled chicken and bread. A large number of cases are said to be cured in three days, but the evidence on which they are termed diphtheritic is by no means conclusive.—*Lancet*, Nov. 22, 1890.

Curgenven on Eucalyptus Oil in Diphtheria.—W. D., aged five, was first seen last Friday, presenting a typical case of diphtheria. Temperature, 102°; pulse, over 130; the throat completely covered with diphtheritic membrane; had had no sleep the night before, being in a high state of delirium. I immediately commenced the treatment, painting the throat freely with a mixture of eucalyptus and olive oil, giving small doses of the former internally, sprinkling it about his shirt and bedclothes, and giving directions that he was to inhale some of the oil in vapor about every four hours. The next day I saw him—less than twenty-four hours afterwards,—he was sitting up in bed playing. His temperature and pulse were almost normal; he had had a good night, with a fair amount of natural sleep and no delirium, and on examining the throat I found only a few patches of the membrane left. The following day the child, with the exception of a little debility, seemed perfectly well, and there was *absolutely* no appearance of any membrane on the fauces. He was out of bed, sitting by the fire, and taking his food well.—*Lancet*, Nov. 29, 1890.

Josias, on Cold Bathing in Typhoid Fever.—In two years the author has treated 36 cases of typhoid with the cold bath, with a mortality of 2.77 %. The patients ranged in age from five to forty years. Of the 36 cases, 27 were benign (regular but hyperpyretic), 9 were grave (adynamic, with intestinal hemorrhage, pneumonia, endocarditis, generalized arterio-sclerosis, etc.). The single fatal case entered the hospital on the sixteenth day of a relapse, and treatment was commenced with the patient *in extremis*. In all cases bathing was commenced as soon as the diagnosis was made, and continued daily without interruption, except during intestinal hemorrhage, during menstruation, and in spite of signs of broncho-pneumonia and renal troubles. On the average each patient took 61 baths; one took only 1, and one took 168. —*Le Courrier Méd.*, Nov. 30, 1889.

Wilson (J. C.) on the Treatment of Enteric Fever with Special Reference to the Method of Brand.—In a service at the German Hospital of Philadelphia, extending from February 1st to July 15th of the current year, I had the opportunity to treat fifty cases of enteric fever. Of these, ten, for reasons chiefly connected with my want of experience in cold bathing, were treated either upon the expectant method or by means of carbolized iodine. The remaining forty were treated in accordance with the method of Brand, with two modifications: first, each case admitted prior to the tenth day of the attack received one or two laxative doses of calomel; second, the temperatures being taken in the axilla or mouth, instead of in the rectum, the bath was regularly administered every three hours so long as the temperature reached 101.5° F. Otherwise the routine method above described was carried out in every particular.

Of the ten cases treated according to the old method, one died, the patient being a man aged thirty-three years, admitted at the end of the second week of the attack, and already suffering from an intestinal hemorrhage. Death occurred on the third day after his entrance to the ward.

Of the forty cases treated by bathing, all recovered. One case suffered two relapses and was much protracted. A second case suffered a single relapse. Intestinal hemorrhage occurred in two cases. Upon the supervention of hemorrhage, bathing was discontinued. The average number of baths in each case was forty-two, the smallest number ten, the largest number one hundred and thirty-eight. These cases showed the favorable effects of bathing in every instance. As a rule, the patients did not object to the baths. When they did so, the objections ceased after a few baths had been administered. Complications were trifling, there were no sequelæ, and in every case the convalescence was rapid and satisfactory.

As I have already taken up much time, I reserve an analysis of the details of these cases for future publication. Suffice it to say that the statements made by European observers were fully realized in this series of cases. Severe symptoms were mitigated, and mild cases ran a most favorable course.

For the sake of comparison I submit the

statistics of some of the hospitals in Philadelphia for the same period of time and for a corresponding period of last year.

Hospital.	Year.	Number of cases.	Average number of days in hospital.	Number of deaths.	Percentage of mortality.	Treatment.
The Pennsylvania Hospital.	1889	31	38	5	16.1	Expectant-symptomatic.
Do.	1890	46	37	6	13.04	
The Episcopal Hospital,	1889	69	44	9	13.04	Mixed, intestinal, antiseptic. Internal and external antipyretic, no baths.
Do.	1890	40	50	5	12.5	
St. Agnes Hospital,	1889	19	36	2	10.5	Expectant-symptomatic.
Do.	1890	15	34	4	26.6	
The German Hospital,	1889	41	36.5	4	9.75	Expectant-symptomatic.
Do.	1890	50	36.9	1	2	10 cases carbolized iodine; 40 strict cold baths.

Two hundred and seventy-one cases on expectant-symptomatic treatment with some antiseptics and applications of cold water, and with 36 deaths, a mortality of 13.29 per cent.; 40 cases with strict cold bathing, no deaths.

Since the 15th of July the strict cold-bath treatment has been uniformly followed in the German Hospital, twenty-four cases having been treated without a death. The statistics of the German Hospital, then, as regards enteric fever, are, from February 1, 1890, to this date, sixty-four cases treated by the cold baths without a death.—*Med. News*, Dec. 6, 1890.

Chassagne (E. J.), on Hydrotherapy—the only Rational Treatment of Typhoid Fever.—The author does not exactly follow the directions of Brand, and prefers to use the warm bath gradually cooled down to 60°; it is to be cooled down by cold water poured in, and the water in the bath is kept in constant motion. The duration of the bath should be not under fifteen minutes nor over thirty; in the majority of cases four baths in the twenty-four hours answer the purpose; in grave cases more baths will be necessary. He gives a bath every time the temperature reaches 102°. The patient ought to take his time in leaving the bath, as he cannot take cold; thoracic complications are not produced by chilling, but produced by the fever; and statistics show that they are more frequent under chemical antipyretics than under the cold bath. If on returning to bed shivering takes place, the patient ought to be gently rubbed, and a hot bottle placed at his feet. In cases where intestinal hemorrhage appears, ice bags to abdomen, instead of baths, and ergotin hypodermically in doses of two to five grains, according to the case.

Typhoid fever in children is not so fatal as in adults, and by using hydrotherapic measures we ought to save most every case.

In conclusion the author says that chemical antipyretics ought to be left aside, as the only good they accomplish is that patients die with a normal temperature. The statistics show cold facts, and ignorance is the only excuse for not using hydrotherapic means.—*Kansas City Med. Record*, Nov., 1890.

Cahall (W. C.) on Salol in Typhoid Fever.—For more than a year and a half the writer has treated every case of typhoid-fever with salol. After eliminating all doubtful cases there remain sixteen cases of undoubted typhoid fever. The drug should be given in three-grain powders every two hours until the morning temperature reaches normal.

It seems to clean and moisten the tongue, lessen gastric irritability, relieve tympanitis, check diarrhœa, and apparently lessen the tendency to hemorrhage. While not checking the fever it apparently controlled it, as the temperature rarely rose higher after the remedy was commenced, and, after a week's treatment, generally fell more or less rapidly. The pulse remains full and seldom exceeds 100. None of the cases observed needed alcohol. The only untoward effect of salol was a partial suppression of urine in some cases, which never necessitated suspension of treatment. Albuminuria was not unusually frequent, nor was any permanent damage done to the kidneys. The only complications seen were two cases of pneumonia and a few cases of slight hemorrhage. The average duration of the cases was seventeen days. There were no deaths. *Med. News*, Nov. 8, 1890.

Poisoning by Sulphonal.—The last number of the *Wiener Medizinische Blätter* contains a short letter by Dr. Breslauer, the director of a private lunatic asylum in the neighborhood of Vienna, in which medical practitioners are warned against using sulphonal too freely. The writer ascribes

the deaths of five female patients to the poisonous action of the sulphonal used. —*Lancet*, Nov. 8, 1890.

Bremer (L.) on Fads and Fancies in the Practice of Neurology, Including Hypnotism.—As regards the injurious effects of hypnotism, we are struck by the divergence of opinion amongst those most competent to judge. Some have only seen beneficial effects—never any injurious results; the experience of others is the very opposite. Charcot, the father of scientific modern hypnotism, warns against its use most emphatically, and holds it in contempt as a remedial agent. He charges it with impairment of intellect. Its tendency to spread like epidemics is a matter of history; and there are evidences of a beginning epidemic in our immediate vicinity. Nervous somnolency, with spontaneous hypnotic spells, general exhaustion, alarming neurasthenic symptoms, epilepsy, somnambulism, hystero-epilepsy, have all been developed after the hypnotic state. A hypno-mania, a morbid craving for hypnosis, has also been observed. Bernheim mentions the fact that persons who have undergone the hypnotic treatment are apt, even in the waking state, to automatically obey not only the hypnotizer but also other people, which means that their individuality is effaced, their will-power paralyzed.

One who has seen the somnambulistic state of epilepsy is at once struck with the close similarity of hypnotic and epileptic somnambulism. I know of a lad who, when still an infant, could be easily hypnotized. Epilepsy has now developed. Again, he that has studied the delusions of the paramaniac or the general progressive paretic, must acknowledge how great is the resemblance as regards the double consciousness with its resulting delusions observable in those types of insanity and a certain stage of hypnotism. This lends color to the view, that it is not only a neurosis, but even a psychosis; that it is, as Meynert puts it, a disease which ought to be eradicated where it exists, but not to be evoked where it does not exist.

I know that hypnotism gives rise to insanity. Eccheverria contends that hypnotism often forebodes, if it is not betraying, insanity. It must be admitted that, like electricity, the telephone, events of a social, political, or religious nature are apt to enter into and form part of the stock of delusions with which the beginning insane may be afflicted. It is quite a common complaint of the victim of delusional insanity that he has been hypnotized; that somebody is enabled thereby to read his innermost thoughts and make him do certain things against his will. In such cases there is no causal relation between hypnotism and insanity, but only a temporal, incidental one.

Among several cases that have come under my observation, in which hypnotism had a contributory effect in developing insanity, and where the patient might have tided over a threatened attack had it not been for certain cranks practising hypnotism, I know of one in whom no heredity, no previous insane diathesis, could be demonstrated, and who went assuredly insane by hypnotic manipulations performed on him at various times in a society of spiritualists. Honest, genuine spiritualism is always a species of insanity, provided there is no mercenary motive at play. All spiritualists are, to say the least, weak-minded, although the fact is urged that some of them achieve wealth and fame. This, of course, is no argument against the existence of feeble-mindedness or downright insanity.

Lest this apparent deviation from the subject-matter may be misinterpreted, I will say that to the average person who places himself in the hands of an hypnotizer, even if this be a physician, spiritualism, mesmerism, magnetism, Braidism, or Bernheimism is all the same thing. He sees in the operator a being endowed with remarkable and supernatural powers, and entertains the most absurd ideas about his person. The road is thus paved to a sort of demonomania.

This was the case with the person just alluded to, a strong and healthy man of forty-five, whose history did not reveal any trace of neurotic or psycho-pathic taint, and who was admitted to St. Vincent's as a dangerous maniac. His ideas centred on hypnotism, he considered himself a great medium, threw himself into trances, had delusions of persecution and poisoning, heard voices, barricaded the door of his room, broke the furniture, attacked the attendants, became entirely rational at intervals, and was saved from permanent loss of reason only by the judicious use of the strait-jacket, which was applied every time he showed symptoms of throwing

himself into a "trance." His recovery was complete, although his illness lasted, if I recollect right, between two and three months. His spiritualistic and hypnotic friends were greatly incensed at not being admitted to the patient, in order to cure him of his "nervousness" by animal magnetism.

Is, in spite of its danger, hypnotism to be recognized as a legitimate remedial agent in medicine? If we accept the definition of the Nancy school, according to which it is no more than increased suggestibility, there could be no manner of question about it. The value of suggestion, *i. e.*, imagination or confidence, is established beyond a doubt and as a matter of course. Is not, in reality, the whole edifice of homœopathy and of the other medical sects built on this groundwork? Consciously or unconsciously every physician practises it. The Nancy school suggest, under circumstances, diseases away without the hypnotic sleep. The sugar granule in the hands of the homœopath, and the cup of catnip-tea in those of the old lady, daily perform wonders by suggestion.

But the question assumes a different aspect when hypnotism proper, that is, artificial sleep, is produced. There is no use in discussing matters of taste, but it seems to me that the average, normal-minded physician would naturally shrink from resorting to a procedure in which every ordinary magnetic quack and mesmeric impostor will excel him. For it must be admitted on all hands that not the more intelligent or skilful, but the more energetic and the brazen-fronted, the man full of self-conceit, has the best qualifications for a successful operator. A good actor is apt to be a good hypnotizer, and the best of this class, *i. e.*, the most unfailing of success, are certainly to be found outside of the medical profession. The whole procedure savors of sham, and the majority of hypnotic sittings are disgusting, on account of the overdoing of things on the part of the "subject." He is, as a rule, a poor actor. The hypnotized girl who is handed straw and is told it is flowers, at which she smells and of which she makes nosegays, excites the suspicion of fraud on account of the exclusively demonstrative overdone gestures of the poor actress. The physician runs the risk, unless he proceeds with extreme caution and discretion, of being judged an impostor by objective observers. Even great celebrities have been accused of theatrical show in hypnotic performances, often justly so; and of downright swindle, for the most part unjustly.

To be brief, hypnotism is not to be entirely eschewed as a therapeutical agent, but it ought to be employed only in affections where other means have been exhausted, and only, as Kraft-Ebing postulates, by those who are well grounded in psychiatry and neuro-pathology. Even such an expert ought to use this mysterious agent with the utmost caution. It will not do to dogmatically judge the merits and demerits of hypnotism, but our experience with it to-day is large enough to limit its uses to functional neuroses of an irritable character. I do not believe that it is justifiable to use it in minor operations, since it is a very dangerous procedure in some subjects, whose susceptibility to its morbid influences it is impossible to calculate beforehand. It acts in some like the first hypodermic injection of morphine, or the taste of the first glass of liquor in the predisposed; it unfetters the fire which has been slumbering under the cinders, and like a stream of burning lava, intensified nerve disturbances rush into channels which before the hypnotic state were only of a rudimentary existence, and which now afford an easy flux of morbid ideas and propositions.—*St. Louis Courier of Med.*, Oct., 1890.

Hypnotism.—Whatever the therapeutics of hypnotism may be, we are safe in asserting that it is a deadly poison to many nervous systems, and that it is the exercise of a power by one man over another which should not be exercised but with the very greatest restrictions under moral, social, and legal sanction. It is too soon to claim for hypnotism what its prophets have so largely claimed, that it is virtually a means of cure or alleviation for almost every disease. That, it certainly will never be; and in attempting by means of hypnotism to cure disease, we are in the position of the American quack who could not cure a case of small-pox, but assured the patient, "I 'll give you something that will put you into fits, and I am 'dead nuts' on fits." In a state of hypnotism, the patient is certainly in a pathological condition. It is a case of mental vivisection, and every experiment leaves him weaker, more impo-

tent, more susceptible to the power of the hypnotizer, more and more of a moral imbecile. It is altogether a dangerous game, and if the good that possibly lies in the practice is to be conserved in the interests of humanity, the sooner we come to a halt and review carefully and judicially the position of matters the better. We do not deny many of the results achieved, but they are unnecessary by these means, and could be attained, if necessary, in other ways. What we assert is, that for these results we sacrifice our individuality, our self-control, our self-respect. We are merely automata, and have lost our moral equation. In view, therefore, of all this, the sooner we hedge in hypnotism with legal restrictions the better.—Editorial in *Med. Press*, Nov. 12, 1890.

Goodman (H. M.) on Albuminuria Following Excessive Use of Paraldehyde.—In May, 1887, I was called to see a woman of fifty-five. She had been considerably worried over family troubles, and being unable to sleep had two months previously consulted a homœopath in her neighborhood. He had prescribed elixir of paraldehyde. She had continued taking the drug in gradually increasing doses, and when I saw her she had been taking from sixteen to eighteen ounces in the twenty-four hours. She was extremely morose, irritable, and apprehensive. The tongue was dry and coated with a brown fur, breath foul, lips cracked, and skin dry and parched. The teeth were discolored and the hair had become very brittle. Her eyesight was very much affected; she was troubled with diplopia, and could not see the clock across the room. Her appetite was gone and she was much emaciated. The examination of the urine made on the second day showed one fourth of one per cent. of albumen, diminished urea, and absence of casts. Subsequent examination, made at intervals of every three days, continued to show the same condition for six weeks, after which it gradually disappeared, and at the end of three months the urine had become normal. Her general condition improved, and she entirely regained her health. Although I have made examinations of her urine every two months since then, I have never detected even a trace of albumen. Knowing her health to have been good, and having had occasion to examine her urine in 1885 and 1886, and also early in the year 1887, before she took the paraldehyde, I am satisfied that the condition of the kidneys was due directly to this cause, and had the drug not been discontinued, it would have terminated in a confirmed albuminuria.

I am indebted to Dr. S. Brzozowski, of this city, for the history of the following case: About a year ago the doctor was called to see a gentleman who was suffering from insomnia. He was a man of family, and his history showed no evidence of any former acute or chronic trouble. Becoming very much worried over business matters, he was finally unable to sleep at night, and had consulted an irregular, who gave him the elixir of paraldehyde. When seen by Dr. Brzozowski he was taking two ounces of the drug every hour or two; in fact, had to be watched to prevent him from taking more. His nervous system was completely shattered, eyesight affected, tongue dry and parched, hair brittle, and all the secretions very much diminished. There had developed over the entire body a vesicular eruption, and these when opened emitted a fetid odor mingled with the odor of aldehyde. Examination of the urine showed a large percentage of albumen; but as no microscopic examination was made, I do not know that casts were present. Being unable to break him of the terrible habit, the patient died shortly afterward, and his death was attributable, so Dr. Brzozowski thinks, to the poisonous effects of the paraldehyde.

Dr. J. G. Kiernan has found the prolonged use of paraldehyde to be followed by the same intractable nasal ulcers, skin eruptions, and other evidences of disturbance of nutrition that are seen after the similar use of chloral. It closely resembles chloral in physiological and therapeutic action, but is not so depressing to the heart as that agent. It has little or no control over pain.

My experience with the drug shows that, aside from its objectionable taste and the odor it imparts to the breath, it may be productive of much injury to the system. I have seen two cases in which the patients had acquired what might be called the "paraldehyde habit." It certainly does not produce a natural sleep, and only too often sets up a gastric irritation, which at times proves troublesome. Its power to antidote poisoning by strychnine is exceedingly doubtful. Its curative properties in mania a potu are on a par with its other

qualities. You frequently run the risk of curing the patients of one habit at the risk of their acquiring another which is by far more disastrous in its consequences. It is my honest conviction that paraldehyde should never be used in any case that requires its continuous administration, and, having better hypnotics at our disposal, its use, even in acute cases, to produce sleep is of doubtful propriety.—*Am. Pract. and News*, Nov. 8, 1890.

Laparotomy under Cocaine.—A woman, aged forty, was admitted as an inpatient under Dr. Barnes, physician to the Cumberland Infirmary, on July 7th. She had for some years suffered from a tumor in the right side of the abdomen. She was advised to submit to an exploratory incision. While she was considering this she rather suddenly became worse. Her abdomen became distended and very tender; she vomited frequently; her loss of strength increased day by day. On October 4th her urgent state was fully explained to her, and she agreed to take such chance of relief as an exploration might afford. Her condition seemed so extreme that she might not recover from a general anæsthetic, so Dr. Maclaren proposed to try if the operation could be done with cocaine. A 20-per-cent. solution was used, and of this 12 minims were injected. Two punctures were made, and the solution injected drop by drop along a line of 2 inches, just under the skin, except for the last two drops, which were injected into the deeper tissues. Five minutes were allowed to elapse, and an incision was then made 2 inches above and parallel to Poupart's ligament. There was no difficulty in doing the operation; the patient never moved. Malignant disease was found, and it was evident that nothing could be done, so the wound was sewn up. The patient died four days after, the course of her illness being uninfluenced for good or evil by the operation. What the patient felt during the operation was very trifling. When questioned she said that it was nothing compared to her sufferings during the previous few days, that it was not greater than she had suffered in her confinements, which had been easy ones, and that what she felt most was the stitching. The introduction of the finger and the passage of a glass tube in various directions to allow fluid to escape were quite painless. At Dr. Maclaren's request she turned on her side to allow the fluid to gravitate to the opening, and afterwards said she felt it running out, and thought it was blood. She was a very thin woman, which no doubt made the use of the cocaine more efficacious and the operation easy. *Post-mortem* examination showed much malignant disease of the peritoneum and omentum, and a distended gall-bladder contained numerous stones, one impacted in the duct. The condition of the wound was perfect.—*Brit. Med. Jour.*, Nov. 1, 1890.

Horsley (J. S.) on the Use of Apomorphine.—Making what would seem the rather unjustifiable statement that apomorphine has heretofore been used for little but its emetic action, the author details some cases in which he has put it to a different use.

In an attack of severe sick headache accompanied by opisthotonos, and in a case of strychnia poisoning it acted admirably as an antispasmodic.

A case of violent palpitation and dyspnœa derived great benefit from its emetic action.

Convulsions following alcoholic excess and shock were relieved in a like manner.

The drug was given hypodermically in doses of from $\frac{1}{10}$ to $\frac{1}{8}$ grain.—*Med. Record*, Dec. 6, 1890.

Juettner (O.) on the Thyroid Gland: the Neurotic Character of Its Enlargements and the Relative Value of the Galvanic Current in Their Treatment.—The author considers it sufficiently established that:

1. Electricity produces no effect in the exophthalmic variety, although there is no better way of making a profound moral impression.

2. Galvano-puncture is a somewhat dangerous but successful method of treating vascular goitres.

3. Electrolysis is of questionable value in any variety of goitre, the good results following its use—even in cases of fibroid goitre—being few and far between.—*Cincinnati Lancet-Clinic*, Sept. 20, 1890.

Ferguson (E. D.) on the Therapeutics of Exophthalmic Goitre.—The writer gives in detail the histories of several cases of exophthalmic goitre treated with strophanthus. The administration of this had afforded prompt relief, the patients being able to return to their ordinary occupation. In no instance had either the exophthalmus or the goitre been entirely

removed, and so far as the latter was concerned, the author would not expect its removal, for when the enlargement had existed for some time it became of so dense or fibrous a consistence as to preclude the idea of its complete removal. There was, however, a notable degree of improvement, both in the exophthalmus and the thyroid body, but it was impossible to express in mathematical terms the changes in these features of the disease, so well as could be done in the rate of the pulse. Not only were the rate and rhythm of the contractions favorably influenced, but in these cures there undoubtedly existed a dilatation of the left ventricle which improved so as to leave no physical or symptomatic evidence of cardiac lesion. Recent pathological considerations tended to place exophthalmic goitre in the category of the neuroses, and to find the locus of its origin in the floor of the fourth ventricle. Still the evidence was not such as to give any clue concerning its etiology or treatment, aside from clinical observations, and subsequently there was no explanation to offer as to the method by which strophanthus afforded relief, aside from the idea that first suggested its use, and that was to relieve an apparently overtaxed heart through the lessening of the resistance in the systemic circulation which was claimed to be its action. Aside from any theoretical consideration as to the way in which the agent acted, the fact remained that benefit was apparently the direct result of the use of strophanthus, a benefit so notable as to almost justify the claim of a cure in some of the cases. The only preparation used by the writer was the tincture, given by the mouth, three times daily, at each meal, the initial dose being from eight to ten drops, which was increased, if necessary, to reduce the frequency of the pulse, to fifteen or twenty, or even twenty-five drops.—*Boston Med. and Surg. Jour.*, Nov. 27, 1890.

French (R. T.) on Death from Intra-Pulmonary Injection.—The following mishap, occurring among the treatment of phthisis by intra-pulmonary injection, is interesting. During part of the writer's term of service as house physician of the Buffalo General Hospital in 1888–89, a large number of cases of phthisis were treated by intra-pulmonary injections. The medicament used was a three-per-cent. solution of beechwood creasote in oil of sweet almonds. Of this about ten minims were injected at a time into a cavity or solidified apex. In most instances the immediate effects were very encouraging. The expectoration usually decreased, and the temperature, after the slight rise caused by the operation, fell, and continued for a time nearly normal. More than fifty such injections had been made with favorable results, when the following accident occurred.

The patient was well nourished and under tonic treatment, and the disease seemed to be in abeyance. Three injections had been made, at intervals of four days, into the left apex, followed in each instance by decreased expectoration and marked diminution of evening temperature.

The fourth injection was made by the usual method into the right apex, and the patient immediately after the procedure resumed his duties about the ward. Twenty minutes later he was seized with violent dyspnœa, which gradually became worse. He had formerly suffered from asthma, and the present attack resembled an asthmatic paroxysm. The irritation caused by the drug on the peripheral endings of the vagus seemed to afford a plausible explanation in support of this diagnosis. The usual remedies for asthma were administered, but all failed to give relief. Auscultation was rendered impossible by the violent tossing and groaning of the sufferer. About an hour and a half after the injection the patient died.

At the autopsy the right lung was found entirely collapsed, and the pleural cavity filled with air. The needle in entering the lung had passed through tissue as thin as ordinary writing-paper into an emphysematous space, communicating with a small cavity, which in turn communicated with a bronchus. After the puncture the thinness of the wall prevented it from retracting sufficiently to act as a valve, and the inspired air must have passed almost directly into the pleural cavity.

Cases of pneumothorax have been reported, following intra-pulmonary injection; but all were slight, and ended in recovery. Only one death immediately following this treatment is recorded, and in that case death was due to acute suppurative bronchitis. Had the pneumothorax been diagnosed in my case at the outset of the attack it is possible that surgical interference might have saved the patient. The

condition, however, was wholly unexpected, and was not recognized by any of the physicians who examined the case.

The slight benefits following this method of treatment are, in the writer's opinion, secured at too great a risk to make the procedure advisable.—*Med. News*, Nov. 20, 1890.

Ward (E. B.) on the Beef-Tea Delusion.—Commenting on the directions for making beef-tea as laid down by a teaching professor, our writer says:

"We take a pound of finely cut beef and pour a pint of cold water on it, and let it stand two hours—while we write about it. The water is not near sufficient to cover the beef, but with occasional agitation we get at the essence. At the end of two hours we find the meat surrounded by a reddish-colored liquid. Put a little of this fluid into a test-tube, and hold it in the flame of a spirit lamp. You see it coagulates to the extent of one fourth, perhaps. What is that? Well, never mind now, we are going to make some beef-tea. Now, we proceed to 'boil the whole.' He does n't say how long, and it does not make much difference so long as the water holds out. Now 'strain and add sufficient water to make a pint.' You perceive that it is too strong and has to be diluted. Let us take a little of this concentrated essence in a test-tube and examine it. Here is a translucent fluid with a bland taste, a neutral reaction, and a slight odor of beef. By closer inspection you observe little fine particles of sediment slowly settling. This, Pavy says, should be stirred up and given with the tea, but as it is only particles of coagula which have skipped through the strainer let us have it out. If part of it ought to come out, it all should. So we will filter this liquid, and you observe we have a limpid, almost colorless, fluid left, and a slight deposit on the filter. What is it? Well, we shall see shortly. Now take a little of this liquid in a test-tube and drop a few drops of nitric acid into it. There is no precipitate formed, so we know there is no albumen or fibrin in it. What is in it? Well, there is a little saline matter, and—a world of disappointment to any one who tries to sustain life with it. That is about all. Why!—Well, the thing is too absurd to talk about. Common well-water containing the average quantity of bacteria is more nourishing.

"Thousands of sick people have been starved to death on this diet, and I want to enter my solemn protest against it before it is everlastingly too late. What you want is the albumen and fibrin of the meat in a condition requiring little digestive power, and that will be readily assimilated. The moment you coagulate these ingredients by heat you render them practically indigestible. These, however, by this process are mostly strained out, and the fluid left is inert, or nearly so.

"Good milk is preferable always, but if you must give beef-tea, *never boil it*. Liebig says 120° F. is the highest temperature to which it should be subjected. It is not very inviting in its general aspect, but it holds in solution the ingredients that you want, and which are rendered useless for a weak digestion by boiling. Liebig's plan is to add a little hydrochloric acid.

"Perhaps there is nothing in the whole round of dietetics, however, that holds so much real needed food in a given space as good rich milk punch—teetotalers to the contrary notwithstanding." — *American Lancet*, Nov., 1890.

Duke (A.) on Local Depletion of the Cervix Uteri.—Taking blood from the cervix uteri, though not so much practised as formerly, is still a valuable aid in some gynæcological cases. I now never puncture the cervix, as the same advantages can be gained by scarification, viz.: merely drawing the end of a rounded sharp knife across the os and cervix, which gives rise to no pain, and has the great advantage of safety, as I have seen severe hemorrhage follow puncture. When the part looks congested and blue, instead of the ordinary light pink, or mother-of-pearl, as some describe it, I make it a rule to take a little blood by scarification; and I use nothing to stop bleeding, as this always ceases when enough blood has flown, as shown by the altered color of the part. In cases of stenosis and flexion, when there is any considerable difficulty in passing the sound, I scarify the part, and when bleeding ceases I have never failed to introduce the sound or point of my dilator. I learned this proceeding from noticing how relaxed the uterus and cervical canal become after hemorrhage from that organ. If more blood is wanted when the bleeding has ceased after scarifying, I fit a sponge into a holder large enough, when moist, to tightly fill the cylindrical speculum, and by moving it up and down, I, in the speculum, produce a vacuum, and thus

cup the cervix. I have found this a useful proceeding in cases of amenorrhœa from congestion. I have also found it useful during the menopause when the patient complained of intense headache, more especially of the vertex, and by drawing blood at regular intervals, and so imitating nature, I have been able to give more relief, and in a far shorter time than by the use of drugs.—*Lancet*, Nov. 29, 1890.

Duke (A.) on the Value of Ignipuncture in the Treatment of Hypertrophied Cervix Uteri.—The length of time occupied by the usual routine treatment of hypertrophied cervix uteri can be considerably shortened by the judicious use of ignipuncture. The usual plans of treatment, namely, tampons of glycerine, copious syringing with hot water, painting the cervix with Churchill's tincture of iodine, etc., occupy a very considerable time, which treatment (unless the patient is willing and able to pay for) "is better kept in the breach than in the observance." Superficial firing by caustics or smouldering pieces of carbon (held in contact with cervix by forceps) is not sufficient in well-marked cases of chronic hypertrophy, at least to obtain the result wished for within a reasonable time; and having seen the good results of ignipuncture in enlarged tonsils, I have given it a trial, and can recommend it as a useful adjunct in these cases.

A thermo-cautery of small size and fine point (Paquelin's) will be found the best, but those who do not possess this valuable instrument can obtain equally good results with a copper rod sharp at the point and a solid bulk about half an inch from the point, so as to retain the heat while the necessary number of punctures are made through a wooden cylindrical speculum. This cautery can be heated in an ordinary spirit lamp till red hot, held in the tissue for a few seconds, when each puncture—¼ inch—is made, and then withdrawn. There should be no bleeding observed if the operation is properly done, such being caused by the cautery being either too hot or too cold.

My practice is to blow in a little boric acid (with my vaginal insufflator) over the punctured surface, and make no examination for a week, when the operation can be repeated if necessary.

I have also found ignipuncture of considerable value in lacerations of the cervix when hardly bad enough to demand Emmet's operation. Very little pain, if any, is produced unless the operator is unwise enough to allow the patient to observe the preliminaries.—*Brit. Med. Jour.*, Nov. 8, 1890.

The Treatment of Burns.—Bardeleben treats burns after the following plan. The injured part is first thoroughly washed with carbolic-acid solution from 2½ to 3 per cent., or with a solution of salicylic acid about 3 in 1,000. All the bullæ are then punctured and the serum allowed to escape, after which the whole part is thoroughly dusted with finely powdered nitrate of bismuth, and a thick layer of cotton-wool applied. The latter is changed whenever it is impregnated with the discharges from the wound. If the burn is a very extensive one, the powdered bismuth may be set aside, and a bismuth ointment used instead. The author affirms that with this dressing cicatrization proceeds rapidly, and there is less discomfort than when any other dressing is employed. Despite the large quantities of bismuth that have been applied no toxic symptoms have been noted in consequence of its use.—*Med. Press*, Nov. 5, 1890.

Prevention of Flea Bites.—In my travelling-bag I habitually carry a small bottle of carbolic acid, on account of the torment which a chance flea inflicts on me. If attacked, I take two or three pieces of waste paper, and upon each put a few drops of the strong acid, then roll them up and place them in different places around me in bed. This effectually ends the annoyance. I think the pungent "disinfecting" acid is the most effectual.—*Brit. Med. Jour.*, Nov. 22, 1890.

Cadeac and Meunier on the Physiological Properties of Oil of Sweet-Flag.—According to the authors oil of calamus aromaticus in large doses has powerful epileptic and tetanic properties. In smaller doses it is only a stimulant, increasing strength without causing ebriety. It always impairs the affectionate disposition of animals, and renders them unruly and stubborn. It has a special affinity for the nervous system; hence it forms an excellent nervine, but may become dangerous in cordials containing excessive quantities.—*Therap. Gaz.*, Nov. 15, 1890.

An Ether Story.—The following *facts*, though perhaps not scientifically interesting, are furnished to us by a correspondent,

who thinks they may afford an amusing item to readers :

Some weeks ago a keg full of ether was washed ashore on the Southern Donegal coast. Those who found it ascertaining it was not drinkable, did not know what to do with it. One, a fisherman, advanced in years, bethought him to try what effect it would have as a local application in the lumbago of his better half. Animated with this touching impulse, he placed her, partially stripped, in position before his cabin fire, and proceeded to use the ether as a liniment, with the aid of the fire's heat. He proceeded industriously for a while, the patient only complaining that it was "very cowld," not differentiating whether that sensation was due to her semi-naked condition or to the ether. However, she had not long to lament on this head, for suddenly the ether caught fire, and between the bottle he held in one hand, the palmful he had in the other, and what was in suspension about the apartment, as well as on her dorsal aspect, there was "a tarrar of a noise and the divil of a blaze." Both suffered some *capillary* scorching only, but the lumbago is cured—for the time.—*Med. Press*, Nov. 5, 1890.

REPORT ON SURGERY.

BY C. A. POWERS, M.D.

McBurney (C.) on Thiersch's Method of Skin-Grafting.—The author reports a number of cases of extensive ulcer quickly closed by this method. The ulcerated surface is freshened, hemorrhage checked by pressure, and washed with a solution of common salt in sterilized water, six parts in one thousand. The grafts consist of thin slices removed by shaving parallel with the surface. They may of course be taken either from the patient or from another individual. Any broad knife may be used in cutting the grafts, but no instrument is so good as a broad razor with a very delicate edge. With this instrument, shavings no thicker than a sheet of note-paper, four or five inches long and an inch broad, may with a little practice be readily made. The surface from which grafts are to be taken should have been thoroughly cleansed and shaved, and then be wet with the salt solution. Taking the razor in the right hand, the operator wets it in the salt solution, and applying the edge at the most distant part of the stretched skin, with a rapid shaving motion toward himself shaves off as thin and long and wide a shaving as he can. Four or five inches in length and an inch wide are about the dimensions of a first-rate graft. Some grafts may be as thin as tissue-paper and others as thick at some parts as card-board. All will do well, but no graft will do well that is so thick as to have fat upon its under surface. The graft being piled up on the razor, a few drops of salt solution should be dropped on it and the instrument be immediately carried to the edge of the surface to be grafted. With a probe, one end of the graft may be slid off the razor to the raw surface, and being held there, the razor may be slid from under it across the surface, so as to unfold the graft and deposit it in place.—*Med. Record*, Oct. 25, 1890.

Elliott (W. K.) on the Use of Plaster-of-Paris in Recent Fractures.—We can entirely agree with the author in his commendation of this measure. For fractures of the arm and leg we know of no dressing which affords equal security and comfort.

As Dr. Elliott says : "The plaster splint holds a position intermediate between the ordinary splints usually applied to recent fractures, and the various forms of permanent apparatus used later on. It differs from the ordinary splint, in that it can retain itself and the broken limb in position, without the use of a bandage, during the critical period of inflammation and swelling, when a retaining bandage keeps the surgeon anxious and ever on the watch. On the other hand, it differs from the immovable apparatus in securing immobility, without the risk of interfering with the circulation.—*Four. Natl. Assoc. Railway Surgeons*, May, 1890.

Monks (G. H.) on a New Method for the Treatment of Injuries to the Shoulder.—Dr. Monks reports about twenty-five cases, including some in which rheumatism undoubtedly played a prominent part. In most of the cases the ordinary methods of treatment had been tried in vain. The result was a more or less perfect cure in about two thirds of all cases tried in a period of time varying from a few days to a few weeks. The most hopeful cases were those which were purely traumatic. The principle involved in the treatment was that the shoulder is more

perfectly in a condition of actual rest when the arm is *supported at right angles to the trunk*, than when the elbow is kept at the side, because (1) the weight of the upper extremity is thus entirely taken off the shoulder, (2) the deltoid and other structures covering the joints are relaxed, and (3) the circumflex nerve and other deeply seated structures are relieved from pressure. In applying this method of treatment, the whole weight of the upper extremity is taken upon a platform-shaped splint, which is supported by a firm band of webbing passing over the other shoulder. The cases for which this form of treatment is especially adapted are those where the prominent symptoms are persistent pain and tenderness in the shoulder, or inability to raise the elbow from the side.—*Boston Med. and Surg. Jour.*, Aug. 21, 1890.

Field (J. R.) on a Case of Fracture of the Coracoid Process.—A boy, five years old, fell and struck partly upon the sidewalk and partly upon a boy's cart behind which he was running. He was unable to tell just what part of the body struck the cart. There was pain upon flexing or extending the forearm and upon raising the upper arm. Tenderness on pressure was present over the outer part of the clavicle and a diagnosis of fractured clavicle was made. Upon removing the clothing, it was seen that both clavicles were alike in shape and position. Closer examination showed that there was no tenderness over the clavicle, but that just below the outer third of the clavicle there was a small prominence of bone tender and movable. No crepitus was obtained. The diagnosis was changed to fracture of the coracoid process. The upper arm was confined to the side, the forearm was flexed to relax the biceps, and a pad was strapped over the process. Good results were obtained as to motion, but the bony prominence still persists.

[A *probable* case, yet these lesions are exceedingly rare, and the evidences in the foregoing notes seem short of being absolutely positive.—C.A.P.]—*Boston Med. and Surg. Jour.*, April 24, 1890.

McCosh (A. J.) on Fractures of the Head of the Fibula.—At a meeting of the Surgical Section of the New York Academy of Medicine, Oct. 13, 1890, Dr. McCosh showed two patients who had sustained this rare form of injury. One was a man of forty-six, who, May 22, 1889, had been injured while in the act of lifting a horse's foot. On examination, the injury was found to consist of a breaking off of the upper end of the fibula, a fragment about three quarters of an inch in length being drawn upward for an inch by the contracting force of the outer hamstring. There was considerable swelling about the outer side of the joint, but no luxation could be produced. The limb was flexed in a double-inclined plane about thirty degrees, and the thigh slightly bent on the pelvis. A strip of adhesive plaster steadied and pulled down the upper fragment. In this position the distance was about half an inch. At the end of three weeks a plaster-of-Paris splint was applied, the leg being semi-flexed. The patient went about on crutches, and at the end of the sixth week the splint was removed. After three months the patient walked without a limp, and his injured limb was practically as good as ever.

A second patient was shown, aged thirty-one years, who had several years before sustained, on two occasions, a fracture of the left femur, and in consequence had had partial ankylosis of the knee joint. On August 26th, while descending some stairs, he slipped, and made a violent and sudden effort to recover himself. In doing so he heard and felt something snap on the outer side of his left knee. He fell, and was unable to get up. Fracture of the upper end of the fibula was found. The upper fragment consisted of the styloid process, which was drawn slightly upward by the biceps tendon. The leg was flexed on the thigh and a right-angled splint applied, a pad pressing the upper fragment into place. Bony union resulted.—*N. Y. Med. Jour.*, Oct. 25, 1890.

Chavasse (T. F.) on Successful Removal of the Entire Upper Extremity for Osteochondroma.—The patient, a male aged forty, was admitted into the General Hospital, Birmingham, in January, 1889, for a large ossifying enchondroma of ten years' duration, growing from the upper portion of the right humerus. The operation performed was resection of the middle third of the clavicle, ligation of the first part of the axillary vessels with carbolized silk, the formation of oval skin flaps, and removal of the remaining outer third of the clavicle, the scapula, and arm *en masse*. Secondary hemorrhage, occurring on the seventeenth day, necessitated ligature of the subclavian artery in the second part of its course. The patient

recovered, and is still living. The tumor itself after removal weighed eighteen pounds. Attention was directed to the systematic method of removal of the entire upper extremity advocated by M. Paul Berger, and to the hemorrhage and shock occurring at the time of and after the operation.—*Lancet*, Jan. 18, 1890.

Fenwick (H.) on Electric Cystoscopy.—This distinguished genito-urinary surgeon lays added emphasis on the recognized value of this procedure.

He says that while watching the ureteral orifices much information can be gained respecting the condition of the kidney by noting the rapidity of the flow and the color of the fluid coming from them. Minor points, such as the condition of proptosis of the orifice, can be made use of in diagnosing the state of affairs beyond the bladder. In one case he had been able to diagnose the presence of carcinoma of the kidney by seeing blood emerge from the uterer and coagulate almost in the act of doing so. In cases of ulceration on the posterior wall of the bladder, with symptoms almost undistinguishable from stone, he had been able to make a definite diagnosis. He had seen many such cases where the patients had been cut for stone. This form of ulceration, when not recognized and not treated, passed into the true tubercular condition, which sooner or later involved the ureters and other parts. It frequently happened that the sound did not detect the presence of stone in the bladder. That occurrence was generally due to the presence of sacculi, in which the stone was more or less encysted, or to a swollen state of the mucous membrane, in which small stones were completely embedded. In these cases, where they could not be felt by the sound, they might be actually seen by means of the cystoscope. —*Med. Record*, Sept. 13, 1890.

Hoty (M.) on Laparotomy for Ruptured Intestine.—A young man received a kick from a horse in the abdomen. The morning after the accident it was found he had symptoms of peritonitis, whereupon laparotomy was resolved upon. It was found that he had not only peritonitis well developed, but on the convex border of a coil of intestine was discovered a complete rupture of the bowel wall. The intestinal wound was sutured, the peritoneal cavity carefully washed out with a weak antiseptic solution, and all was followed by a satisfactory cure, notwithstanding the giving way of the abdominal wall suture, which led to healing by second intention.—*Lancet*, June 14, 1890.

Fowler (G. R.) on the Preparation of Catgut.—The author presents a plan of procedure which, after practical trial as well as experimental study, has thus far proven thoroughly effectual, and at the same time possesses the advantage of simplicity. The method consists simply in boiling the catgut of commerce for one hour in ninety-seven per cent. alcohol, the boiling-point of which is 183° F. Under this treatment the gut ceased to produce infection, which had previously been a frequent cause of an interruption of the healing process in a number of instances, in spite of my best care ; in addition to the advantage thus gained, it was found that the tensile strength was increased, and the tendency of the strands to slip through the hands while tying, and the knots themselves to become loosened from the same cause (slipping), was markedly lessened. As for the behavior of the catgut in the tissues, there seems to be but slight change effected in its structure, so far as its absorbability is concerned. I have thought that sutures held somewhat longer after this method of preparation than in the case of catgut prepared after other methods, with the exception of the chromic gut of Lister. This is rather an advantage than otherwise, particularly in trachelorrhaphy and perineorrhaphy cases.—*Med. Record*, Aug. 16, 1890.

Tait (L.) on Surgical Training.—This distinguished surgeon, after referring to the value of a good, general education, raised his voice in protest against the absurd attention to detail and the enormous waste of time involved in the present biological training of the surgeon student. Let him be grounded in every fact of anatomy which might, under the rarest and most unlikely conditions, aid him to appreciate the results of an injury, or a displacement, or of a new growth ; let him be grounded in all such items of information concerning the ultimate structure of organs and their mediate and immediate functions, and the changes to which disease subjected them. Let him be placed so constantly alongside somatic sections that he would not only learn his anatomy, but that he would never forget it. But he pleaded most earnestly that the successors of his hearers should be spared that sense-

less grind at useless details of anatomy with which their own young memories had been burdened—details which he could remember only by a demoralizing system of catch-words, details which he prepared himself to forget the moment the necessity of examinations was over. He remembered that they had to learn that the direction of the anterior cornu of one of the ventricles of the brain ran a course which was backward, outward, downward, forward, and inward, and they were enabled in the most improper way to remember these important facts by the word "bodfi." Had "bodfi" ever served any of his hearers at the bedside? Was there any conceivable condition of human accident or ailment in which "bodfi" could assist them to relieve their patients? The students who continued to learn such matters would find, as he had done, that they would be of no assistance to them to estimate the character of a delirium, and no amount of knowledge of the arrangements of the electrical currents in muscular fibre would help them to determine the proper relations of a splint.—*N. Y. Med. Record*, Aug. 30, 1890.

REPORT ON CUTANEOUS DISEASES AND SYPHILIS.

BY CONDICT W. CUTLER, M.D.

Noyes (A. W. F., Jr.) on New Forms of Application in Skin Diseases.—1. *Plaster mulls* are composed of oleate of alum and gutta-percha, with which drugs are incorporated, the whole being spread in a thin layer on muslin. They are cleanly, readily applied, are in constant contact with the diseased part; they protect from external irritants, and are comfortable to the patient.

2. *Glyco-gelatines* are composed of a combination of glycerine and gelatine with oxide of zinc, which makes a solid mixture; there are two forms (A soft, B hard,) composed as follows:

A (SOFT).		B (HARD).	
Zinc oxide	15 parts	Zinc oxide	10 parts
Gelatine	15 "	Gelatine	30 "
Glycerine	25 "	Glycerine	30 "
Water	45 "	Water	30 "
	100 parts		100 parts

Iodide of lead, precipitate, chrysarobin, sulphur, and iodoform, are all miscible with either in any proportion—5 to 10 per cent. is a suitable proportion for the first three mentioned, 20 to 30 per cent. for the last two. Carbolic acid, salicylic acid, resorcin, naphthol, creasote, and sulphide of potash exercise an inhibitory action on the setting of the gelatine, and should only be incorporated with the hard variety up to 10 per cent. Fats, balsams, tars, and ichthyol have a diluting and loosening effect, and should be prescribed with the hard variety, and not in larger proportion than 33 per cent. Substances in powder form may be used, but never in greater quantity than the proportion of gelatine. Camphor and chloral may be incorporated up to 2 per cent., ext. cannabis indica to 5 per cent., hydrarg. perchlor. up to 3 per cent.

The method of application to diseased parts is excessively simple. The solid glyco-gelatine is melted in a hot-water bath. It is then applied with a paint-brush to the affected region, and dabbed over immediately afterwards with a roll of absorbent cotton-wool; thus a sort of skin is formed, which acts as a protector and as a medium, by which the medicaments may be kept in constant contact with the skin. Besides this, it acts beneficially by its slight compressing effects, producing a localized anæmia, also favoring the absorption of inflammatory products.

3. *Salve and paste sticks.*—Salve sticks are made by a combination of olive oil and wax, to which the required drug may be added. Paste sticks contain no fatty elements, and are easily dissolved by the aid of moisture. They are indicated when the epidermis is absent, as in ulcers, mucous patches, chancres, etc.—*Australian Med. Jour.*, Aug. 15, 1890.

Œsipus.—Œsipus is the name which the ancients applied to the untreated wool-fat derived from the fleece of sheep. As every one knows, the modern process of deriving this fat, and subsequently cleaning it, has given us lanolin. M. Ihle, however, claims (*Monatshefte fuer praktische Dermatologie*) that whereas lanolin makes an excellent ointment basis, the crude wool-fat is a true therapeutic agent possessing certain valuable properties; that it contains certain substances whose combination acts upon the skin very favorably, and which are removed in the process of purification.

He has made a number of therapeutical experiments, and has found that it is an excellent keratolytic agent, acting very well upon the hyperkeratoses, such as corns. In addition to this it has marked antiseptic properties and its use would seem to be indicated in the treatment of wounds. It is found very useful in the treatment of ringworm and sycosis.

The possibility of contracting anthrax from its use should, however, be considered.—*St. Louis Med. and Surg. Jour.*, Dec., 1890.

Jackson (G. T.) on Electrolysis in the Treatment of Lupus Vulgaris.—Dr. Jackson, in the treatment of lupus vulgaris by electrolysis, uses a current of a strength of about seven milliampères. He gives the advantages of the method as follows: 1°. It is comparatively painless, and there is no need of putting the patient under an anæsthetic. 2°. There is not the slightest loss of blood, and thus there is no dread of a surgical operation on the part of the patient. 3°. The patient is not kept a moment from his regular business, as there is no deformity caused by the operation. The part looks no worse after the operation than before. As no after-treatment is required, he is not obliged to go about with a patch of more or less unsightly plaster on his face. He is also spared the discomfort of a swollen face and eyes, the ordinary attendant on the arsenical or pyrogallic-acid treatment. 4°. The treatment goes to the root of the disease, to the bottom of the tubercle, with far more exactness and less damage to the surrounding skin than any other caustic or surgical method. 5°. The scar left is smooth and not unsightly. 6°. The result obtained is as good if not better than that by any previous method.—*St. Louis Med. and Surg. Jour.*, Dec., 1890.

Kolbasenko on the Treatment of Corns.—Dr. Kolbasenko, in the *Russkaia Meditsina*, gives the following mixture as very serviceable in the treatment of corns and callosities:

℞ Acidi salicylici,
Acidi lactici. . . . āā 5.0 (ʒ jss.)
Collodii . . . . . 40.0 (ℨ jss.)
M.—To apply by means of a brush.

The foot should be kept for a few minutes in very hot water before each application, in order to soften the corn and make it thus more penetrable for the acids. The adjacent healthy skin should be protected from any irritating action of the acids by powdering with iodoform. Even very large and thick horny deposits on the sole are said to fall off *in toto* after six or seven applications.—*Pacific Med. Jour.*, Nov. 1, 1890.

Bulkley (L. D.) on Treatment of Lichen Planus.—The alkalies, in large doses, not only served to mitigate the sufferings of the patient, but arrested the further development of the eruption. Acetate of potash, in combination with nux vomica and a bitter infusion, taken after meals, had served him about the best. He had also found very useful an empiric sort of a prescription of Boeck, of Norway, consisting of from ten to twenty grains of chlorate of potash dissolved in considerable water, directly after each meal; followed in half an hour by twenty drops of dilute nitric acid well diluted. After a cooling course of some such character a more tonic treatment was often required, and there was nothing better than sulphate of iron with sulphate of magnesia and sulphuric acid, in what is known among dermatologists as Startin's mixture. Arsenic he thought of very little use in this eruption. Indeed, in the more acute stages, it even seemed to aggravate it.

Locally something could be done by proper measures both in the way of relieving the general suffering and checking the disease. Among the applications mentioned were calamine and zinc lotions, carbolic acid and glycerine, and a ten-per-cent solution of ichthyol. Carbolized vaseline served admirably in certain cases. Unna had claimed to cure his cases by local measures entirely, and the main remedy that he used was bichloride of mercury. Dr. Bulkley was sceptical about cures being effected by this agent alone, but in many cases it acted well, in the proportion of two or three grains to the ounce of zinc or diachylon ointment. A good combination was the following:

℞ Acid. carbolic. . . gr. xx.
Hydrarg. bichlor. . . gr. ii.–v.
Ung. diachylon. . . ʒ i.

As to bathing, plain water baths were injurious rather than beneficial, but medicated baths were of considerable service, such agents as starch, bicarbonate of soda, and borax being called for in this connection.—*Boston Med. and Surg. Jour.*, Nov. 20, 1890.

The Treatment of Syphilis by Subcutaneous Injection of Mercurial Preparations.—Dr. Deloir and Dr. Tavernier, of Paris, having practised this method of treating syphilis in all sorts of syphilitic cases during two years, now (*Giorn. ital. d. mal. ven. e del pelle*, 1889, xxiv., 247) give a statistical report of their experience and a summary of their conclusions. In all they made 1,573 injections. Of these, 875 were of one part calomel to twelve parts liquid vaseline, a half Pravaz syringeful being thrown into the sacro-lumbar muscles, and repeated once a week; 642 were of the yellow oxide of mercury, prepared and used in the same manner as the calomel; and 56 were of "gray oil," consisting of twenty parts of pure mercury, forty parts of liquid vaseline, and five parts of the ethereal tincture of benzoin, of which a third of a syringeful was injected every ninth day.

The calomel injections produced the greatest number of disorders. The gray oil is the most inoffensive, but also the least active. The practical deductions from their experience are: 1. The use of subcutaneous injections of mercury should be limited to the early eruptions on the skin. 2. They may be resorted to when it is necessary to produce a very rapid effect on these eruptions. 3. They are specially if not exclusively applicable to hospital patients, or to those who can remain in bed for a few days. 4. It is a good means for treating prostitutes. 5. Its action upon mucous patches is very bad. 6. It does not prevent relapses. 7. In many cases it fails to cure, and recourse must be had to inunctions. 8. It should not be used against the late syphilides except in those exceptional cases in which it is necessary to use mercury internally at the same time with its local use and the administration of the iodide of potassium. 9. It is contra-indicated in cerebral and spinal syphilis, in visceral syphilis, in pregnant women, and in infants. The only advantage of the method is the rapidity of its action. But this advantage is more than balanced by its inconveniences.—*New York Med. Jour.*, Aug. 9, 1890.

Neuhoff (F.) on the Treatment of Pruritus.—Among the external applications, the one which stands at the head of the list as an antipruritic, or remedy to control itching of the skin, is known as campho-phenique. It is certainly one of the most useful antipruritics we have on the list. It is, I believe, a mixture of equal parts of camphor and carbolic acid rubbed together, and is in the form of a liquid. This application will in almost every instance control local pruritus, but it must be applied carefully. If it is applied too freely it will act as an escharotic and produce exfoliation of the superficial parts of the skin. It should be applied in the undiluted state, and not oftener than once a day, or every other day, and in some cases once in three days is often enough, as the itching does not usually return for several days after each application. Of course, it is only mentioned as a palliative measure, but it does seem in some cases to have a more or less curative effect.

One of the most useful means in the treatment of this disease I have not as yet mentioned. I refer to the use of electricity. Electricity is not only palliative, but it seems to have a curative effect. It may be used either in the form of the galvanic or faradic current, applying it to the surface about as strong as the patient can comfortably bear, the guide as to the strength of current being the feelings of the patient. I believe that, as a rule, the faradic current is more beneficial than the galvanic, at least I have had better satisfaction with it, especially in those forms wherein the disease is general in character. In the treatment of that form of pruritus which we see during the cold months of the year, I have had better success with electricity than by any other means.—*Weekly Med. Review*, Aug., 1890.

Bronson (E. B.) on the Sensation of Itching.—Dr. Bronson draws the following conclusions as the result of his investigations on the sensation of itching:

1. That there was a sense of contact independent of the sense of pselaphia.

2. That this sense of contact was the sense disturbed in pruritus.

3. That it primarily concerned simple cutaneous nerves or nerve endings situated superficially and probably in the epidermis.

4. That the disturbance in pruritus was of the nature of a dysæsthesia due to accumulated or obstructed nerve excitation with imperfect conduction of the generated force into correlated forms of nervous energy.

5. That scratching relieved itching by directing the excitation into freer channels

of sensation—sometimes, especially when severe, substituting for the pruritus either painful or voluptuous sensations.

6. That the voluptuous sensations which might attend pruritus were a manifestation of a generalized aphrodisiac sense, representing a phase of common sensation that had its source in the sense of contact.

While some of the phases of itching might be associated with pathological changes in the epidermis, others had their source more deeply situated and were referable to the nerve centres. To the latter belonged the form of neurosis of which pruritus was at the same time the symptom and the sole appellation. Still other sources were doubtless to be found associated with apparently normal physiological conditions. While those represented the most obvious sources of itching or provocations for scratching, there was another factor of which hitherto but little account had been taken. Both the English words itch and itching, and the Latin prurio and pruritus, in their secondary significations conveyed the idea of a longing, teasing desire, while pruritus was commonly used by the Latins as a synonym for lasciviousness. By desire, something more was meant than merely the inclination to brush or scratch away a foreign body, of which the sensation was apparently an intimation. It was rather a kind of desire closely akin to a lustful feeling and one that sometimes made scratching veritably a 'sensual indulgence. When pruritus reached a certain degree of intensity, the subject was not content with that moderate amount of scratching that would ordinarily create a sufficient diversion to give relief, but there was a disposition to attack the itching surface with a vehemence that amounted to a passion. Recognizing this peculiar element of desire in pruritus, the sexual excitement and depraving tendencies that were so commonly associated with pruritus genitalium were most easily explained. But it was not so surprising that voluptuous sensations should attend itching where they had their natural seat; such sensations were, however, not confined to the genitalia. They might be concomitants of itching in almost any situation. By means of a violent excitation induced by severe scratching, provoked by pruritic irritation, a liberation or discharge of nervous energy took place accompanied by pleasurable sensations, together with the relief of the pruritic irritation. A temporary inertia and rest followed and continued until a renewal of the pruritus provoked another resort to the same method of relief. As to why these processes were attended with pleasurable sensations, it sufficed to say it satisfied a law of being. Gratification of appetite was a condition of life, either of the preservation of life or of the reproduction of life. The sexual, the aphrodisiac appetite could only be secondary to the instinct and appetites of self-preservation.—*N. Y. Med. Jour.*, Nov. 15, 1890.

Fruger (E.) on Syphilis as an Infectious Disease in the Light of Modern Bacteriology.—E. Fruger in the *Archiv für Derm. und Syph.*, 1890, Hft. 3, fo. 331, says: Besides the specific virus of syphilis, the ptomaines which are the result of chemical changes caused by the presence of virus, give rise to many of the symptoms of syphilis and infects the fœtus *in utero*.

I. In the primary stage of syphilis we are quite sure that the ptomaine very early enters into the blood and lymph circulations and is distributed throughout the body. The amount of the ptomaine increases in geometrical proportion to the increase of the virus, and produces that general intoxication of the whole body seen at this time. At the same time with the general diffusion of the ptomaine through the circulation we have also a diffusion through the tissues in the neighborhood of the initial lesion. As expressions of the intoxication we note: 1. Immunity from further inoculation with the virus. 2. General symptoms, such as anæmia, fever, prostration, weakness, pains in the limbs and joints, albuminuria, icterus, neuralgia, and hyperæmia of the retina, all of which are too ephemeral and unstable to be due to a deposit of the virus itself. The fact that iodide of potassium exerts a healing effect on these symptoms while it has little if any influence upon the sclerosis, and, on the other hand, mercury influences favorably the latter but not the former, shows that there is a different chemical reaction in them, and strengthens the idea that they are due to different causes. II. The secondary stage. The various secondary lesions are due, without doubt, directly to the virus, but the constitutional symptoms are probably due to the ptomaine, as well as the seborrhœa, alopecia,

and dryness of the nails. In malignant, precocious syphilis it is probable that the profound intoxication of the system by the ptomaine is responsible for the severity of the symptoms. In the latent period which follows the secondary stage we do not know what becomes of the virus in those cases in which later symptoms show themselves. Nor do we know when the virus leaves the system in those cases in which complete recovery seemingly takes place. During this period many subjects are not quite in normal condition. The most noticeable fact of this period is—III. The immunity against new infection. How long this immunity may last we do not know. That it probably is in some cases limited is shown by the well-authenticated instances of reinfection. Immunity does not prove that the individuals are still syphilitic any more than the immunity acquired from having had variola indicates that the individual still has variola. This immunity is due to the influence of the ptomaine upon the tissues, and may be acquired without passing through the active stage of syphilis. This is seen in the acquiring of immunity to infection on the part of the mother of a child syphilitic by the father. While it is possible for the virus to pass through the placenta from the fœtus to the mother, it is uncommon. But ptomaines must so pass, and while these are not capable of producing syphilitic lesions, they do render the mother immune to further infection with syphilis. The same thing occurs and produces like results when a healthy child is born to syphilitic parents. IV. The tertiary stage. It is the opinion of the majority of syphilographers that this stage is not the direct result of the syphilitic virus, but a consecutive diathesis, the virus having been eliminated. In support of this opinion we find: 1. The relative rarity of tertiary symptoms. 2. Their late appearance after infection. 3. The difference in the disease picture. 4. The non-contagiousness of the disease at this time. 5. The non-transmissibility of the disease. 6. The possibility of reinfection. 7. The different chemical reaction to mercury and iodine. 8. The fact that tertiary symptoms, like immunity, can occur in individuals who have never shown signs of primary or secondary syphilis. We see this both in the mothers who have gained immunity by carrying syphilitic fœtuses, and in children of syphilitic parents who, though never showing signs of active syphilis, exhibit great disturbances of nutrition, or pure tertiary lesions, late after birth.—*N. Y. Med. Four.*, Dec. 6, 1890.

Fournier (A.) on Syphilis by Conception.—A young girl, sixteen years old, virgin, became pregnant following one coition. The young man, the ravisher of this virginity, had syphilis six months previously; but for a month no symptoms whatever were present. Frightened at the possible consequences, he came the next day to consult M. Gailleton, who examined him thoroughly, but could not discover any specific lesion, and reassured the imprudent youth. But the young girl, who became pregnant, presented, two months afterward, the following symptoms: violent headaches, roseola, mucous plaques; in a word, a syphilis clearly characterized, and without a trace of chancre. Before such facts doubt is not possible, and we may say that syphilis through conception takes its place in medical science.

As to the mechanism by which the infection is transmitted from the fœtus to the mother, it is a problem which has not been solved as yet. Is the infection transmitted by the ovum when in the tube, or after it reaches the uterus? Or, does not infection take place later, through the placenta, after the ovum is grafted to the uterine cavity? There are many suppositions, which would bring us into discussion without end.—*Buffalo Med. and Surg. Four.*, April, 1889.

Bulkley (F. D.) on Unusual Methods of Acquiring Syphilis.—Dr. Bulkley reports sixty-six personal cases of chancre which were undoubtedly the result of non-venereal infection, and has classified them as follows:

1. *Syphilis economica*, where in the ordinary economic relations of domestic and industrial life the disease is transmitted, innocently, from one person to another.

2. *Syphilis brephotrophica*, where the disease is acquired by or from infants, in connection with their nourishment and care.

3. *Syphilis technica*, where the opportunity for the transference of the poison occurs in connection with various forms of body-service, medical and surgical, or of like nature.—*Med. News*, March 2, 1889.

Brugger, on Tuberculosis Verrucosa Cutis.—Dr. Brugger, in *Archiv für Path. Anat. und Phys. und für klin. Med.*, 1890, Heft III., says: In a case of tuberculosis verrucosa cutis, recently examined, were found tubercle bacilli, and inoculation experiments upon a guinea-pig were successful, the animal dying of tuberculosis within six weeks. Brugger believes that this is the first time that an attempt has been made to inoculate an animal with a piece of a lesion of tuberculosis verrucosa cutis, and that the positive result is of great value in deciding the nature of the disease. It is to be diagnosticated from lupus by an absence of the characteristic lupus tubercles, by its having no disposition to return in the cicatrices, and by being more superficial. Otherwise their course is very much alike. From syphilis the diagnosis is made by an absence of the infiltrated wall and dirty brown-red color of the syphilitic ulcer, by its much more chronic course, and by the more deforming cicatrices that it leaves. It is probable that the so-called verruca necrogenica is the same as tuberculosis verrucosa cutis. Why infection of the skin by the tubercle bacillus should at one time produce lupus, at another time a tuberculous ulcer, at another time verruca necrogenica, and at yet another time tuberculosis verrucosa cutis, is a yet unanswered question. It is probable that individual peculiarities have something to do with it. The virulence of the poison may also play a part in determining the nature of the lesion. It is possible to have a general infection of the system follow a local infection, though this is exceptional. This event may take place either through the lymphatics or through the blood.

The treatment must be by destruction of the lesion by excision, by scratching out with the curette, by caustics, or by a combination of either of the first two methods.—*N. Y. Med. Four.*, Dec. 6, 1890.

Duhring (L. A.) on the Treatment of Dermatitis Herpetiformis.—A speedy cure was not to be looked for. It must be remembered that the disease, as a rule, was multiform in character, and the several varieties naturally called for different formulæ, especially as to the strength of the remedy. His experience had been that milder remedies were called for in the erythematous than in the vesicular and bullous forms. A difficulty to contend with was the tendency of the disease to repeat itself, a new crop coming out before the older ones had disappeared. Almost all his cases had been chronic, and had previously undergone all manner of treatment. He had long since arrived at the conclusion that most benefit was to be derived from stimulating applications, especially those which acted as revulsives—tar, carbolic acid, sulphur, thymol, ichthyol, resorcin, etc. That which had proved of greatest value in his hands had been sulphur ointment, two drachms to the ounce, applied by thorough and long rubbing, so as to make a positive impression upon the skin, causing, as it were, local shock. Special emphasis was placed upon the manner of making the application. Internal remedies had proved of little avail in most cases.—*N. Y. Med. Four.*, Sept. 20, 1890.

Alcoholic Purpura.—M. Poirrier has devoted considerable attention to alcoholic purpura in his Thèse de Paris, 1890. He states that alcoholic purpura is stubborn, chronic in its course, and very subject to relapses. It is often limited to the extremities, but its predilection is for the face, neck, and buttocks. The lesions vary from a simple congestion to hemorrhage infiltration. The petechiæ frequently fuse into an erythema, which finally becomes a purpura. Alcoholic purpura is to be classified as a toxic purpura. From an ætiological point of view we have to deal here with various changes occurring in the blood, the walls of the blood-vessels, and nerve centres, whose vasomotor functions are disturbed. In a few rare cases the pathogenetic factor lies in a neuritis; in such cases there will be found accompanying sensory, motor, and trophic disturbances.—*St. Louis Med. and Surg. Four.*, Nov., 1890.

Hairs as Records of Emotional Disturbances.—Dr. Pineus, of Berlin, claims to be able by the aid of the polariscope, to detect certain traces of past emotions in the hair. He explains that under the influence of mental disturbances of a violent kind, the hairs become decolorized at the junction of the lower two-thirds with the upper third, reckoning from the surface of the skin to the root of the hair. The observation, if exact, is interesting, but the recollection of such emo-

tions is generally too vivid to render any artificial aid to memory necessary. If Dr. Pineus could only devise a means of detecting emotions to come, his *procédé* would excite a vast deal more curiosity.—*Med. Press*, Aug. 27, 1890.

Bulkley (L. D.) on Psorospermosis Follicularis Cutis.—In regard to the true nature of this complaint, whether these bodies called by Darier *psorosperms* are in reality parasites, and whether they are the true cause of the disease, we unfortunately have as yet no means to determine absolutely. All efforts to cultivate these bodies have failed, nor has any one succeeded in inoculating animals with the disease, although several attempts have been made. The malady does not seem to be communicated by ordinary means, for three of the nine patients were married men, living with their wives, to whom the disease was not communicated. This, however, proves little, for tuberculosis may likewise exist under similar circumstances without infecting others, and it is only very recently that the contagiousness of the latter has been proved; also, tinea versicolor, known to be due to a vegetable parasite, is rarely communicated from husband to wife. But, as already mentioned, Boeck reported a father and two sons affected by the disease, which he considers proof both of contagiousness and of the coccidia as its cause. Unfortunately, the cases were only detailed at a society meeting in Norway, and I have been unable to find a full account or description of them. Several able French and other microscopists and naturalists have agreed as to the parasitic character of the bodies referred to, and the evidence seems very strong that they are the producers of the disease in question.

But the most interesting and perhaps important part of the question lies in the fact that more or less similar bodies have been found in the tissues of several other maladies, which are quite distinct from the present one, and from each other, in their clinical features. So marked are these microscopical characters that Darier has proposed the name *psorosperms cutanées* to designate the group in which they should be placed. The first of these diseases is the so-called molluscum contagiosum with which all are familiar. This disease Neisser, Darier, and others cited by them, believe to be due to the presence in the epithelial cells of similar parasites—the so-called "molluscous bodies" which have long been known; these resemble in a certain degree the psorosperms already described, and are thought to be identical or at least analogous to them.

These curious round bodies have also been found by Darier, Wickham, and others, in that peculiar form of epithelioma of the nipple known as Paget's disease; and Darier further states that Malassez, in 1876, "noticed in a large number of epithelial tumors, cellular bodies, granular or refracting, sometimes encapsuled, which presented certain analogies to the psorosperms of the rabbit," and that Cornil has reported having seen analogous organisms in certain cancers of the uterus.—*Medical News*, Nov. 8, 1890.

REPORT ON DISEASES OF THE EYE AND EAR.

BY A. T. MUZZY, M.D.

Millikin (B. L.) on a Case of Foreign Body Remaining in the Eye Twenty Years, Followed by Abscess in the Scleral Wall.—When ten years old a piece of gun-cap was exploded into the right eye. The patient is now twenty-nine, and during this period of eighteen years he has had four attacks of severe inflammation with pain and diminished vision. In the intervals vision has partially improved. In February, 1888, when first seen, the corneal scar was plain; there was a slit through the corresponding point of the iris; an opaque track in the lens; and a grayish-white body projecting into the vitreous seen both through the rent of the iris and through the pupil when dilated; there was also a broad choroidal crescent and numerous floating opacities in the vitreous. There was tenderness, injection and an eroded appearance of the sclera over the seat of the foreign body. Inflammation subsided only to be renewed in September, 1889, which progressed until December, when an enlargement of the sclera appeared over the position of the foreign body. This was hard and quite tender. No change appeared within the eye. On January 14th last a needle was passed through the most prominent portion of the projection until it came in contact with a hard body. Then a triangular piece of conjunctiva was dissected from the

sclera at this point and a free incision made into the swelling. Three or four drops of pus escaped and the anterior walls of the sac collapsed. With a spoon a number of black particles were removed, and also as much as possible of the interior of the sac. The patient recovered without a bad symptom, though suffering considerable pain in spite of the cocaine during the operation. Vision by January 22d = $\frac{3}{xxx}$. The patient, a merchant, is able to work steadily at his business.—*Med. News*, Nov. 8, 1890.

Williams (A. D.) on Atropine Solution in the Eye Producing Mental Aberration in a Child.—The child's eyes had been operated upon for convergent strabismus. A few hours later the eyes diverged somewhat for distance, but in accommodation one or the other of them turned far inward. To relax the focusing power and the consequent tendency to converge a 4-grain solution of atropine was instilled. This in twenty-four hours rendered the child completely demented. I have reported several cases already of this effect, as in old people after cataract operation.—*St. Louis Med. and Surg. Jour.*, Nov., 1890.

Burnett (C. H.) on Permanently Good Results of Excision of the Membrana Tympani and Malleus in a Case of Chronic Aural Vertigo; Also in a Case of Chronic Suppuration of the Tympanic Attic.—In 1881 a case of chronic middle-ear catarrh was attended; all known methods of treatment were found unavailing to stop the discharge or remove the tinnitus. No vertigo existed at this time. In 1888 the case reappeared with attacks of aural vertigo added. The malleus was found bound down to the promontory. Under ether, the malleus and tympanum were removed. All tinnitus and vertigo disappeared; have not reappeared for the two years since. This would prove the mechanical and not neuropathic origin of Ménière's disease. The second case was a typical one of inveterate "attic disease." This came to me one year ago with history of catarrhal condition of nose and ears in childhood and again for past six years. During this latter period polypi have been at different times removed, but the offensive discharge has not been stopped, though treated by the best surgeons of this country and Europe. When first seen, hearing in the affected ear was *nothing*. With an electric head-lamp, under ether, the malleus and drum were excised, showing necrosis of the anterior free portion of the head of the malleus; no other necrotic points were detected. Healing has so far followed that at present all discharge has ceased, a delicate new membrane has formed, and hearing with this ear now amounts to fifteen feet for whispered words.—*Med. News*, August 16, 1890.

Tilley (R.) on a Mastoid-Bone Knife.—In operating on the mastoid the choice has been between the chisel and mallet and the drill. The disadvantage of the drill is the difficulty of detecting as quickly as we wish when the operation is nearing completion; also the crushing of the bone, leaving fine splinters to necrose and mar the effects of the operation; nor is it possible to change the course after the operation has once begun.

The disadvantages of the chisel, on the other hand, are the need of relatively a wider field for operating in a region where a large external wound is not at all desirable; then, if any meningitis exists, the series of slight concussions from use of the mallet while chiselling away the external plate is a great drawback.

While uniting with most of the best observers in a preference for the chisel over the drill, I present this modification, the ordinary farrier's knife, which has given me good results over either of the older instruments. The modification is simply a shortening to bring it still further under control. It is possible with this to perforate the mastoids in a very short space of time.—*Western Med. Report.*, Nov., 1890.

Green (J. O.) on Treatment of Inflammation of the Mastoid.—Out of about two hundred and fifty mastoid operations the records of the last eighty are classified, and the following results and features noted. The most fatal form is when the inflammation extends downward through the base of the mastoid. The diagnostic symptoms are: first, history of an existing or preceding tympanic trouble, the majority are attended by an otorrhœa; pain over the mastoid and the side of the head are very common; sensitiveness of the bone on pressure I consider the best simple symptom, and should be carefully looked for; œdema of the upper posterior wall of the meatus close to the membrane is, when it exists, almost a certain sign of mastoid inflammation; œdema of the ex-

ternal tissues is the most common indication that pus is forming beneath the periosteum, though it may exist without pus being present; fluctuation is a very uncertain symptom; persistent tympanic suppuration in spite of thorough treatment, and when no other cause for the chronicity can be found. A diagnosis of the exact condition previous to operation is impossible in a large proportion of the cases. While sclerosis is more probable in a chronic case, yet it is certainly met with quite often in very acute cases, where no history of previous inflammation is obtainable. The amount of pus found varies greatly; it is really abundant only in cases of suppuration of the mucous membrane; in osteomyelitis and caries it is often so small that it can easily be overlooked in the free bleeding from the granulations. All the different methods have been employed, but for the last three years the gouge and mallet have been used for opening the bone, and the dental-engine afterwards with burr move the drill for its rapid cutting and its capacity for delicate handling. A communication with the tympanum, as indicated by the passage of fluid from the wound into the meatus or Eustachian tube, is rather the exception, and is not necessary for the most rapid and perfect cure.

The use of metallic drainage-tubes has long since been given up, rubber answering every purpose. General antisepsis, with abundant irrigation, is used. The ear is dressed daily. To stimulate granulations in bare bone iodoform, either in powder or ethereal solution, is employed. Several times the dura mater and lateral sinus have been exposed in removing sequestra, but without any injurious effect.—*Am. Jour. Med. Science*, Dec., 1890.

Williams (A. D.) on Aristol in Otorrhœa.—In three cases recently treated it dried the discharge for one day, after which the discharge returned, but was promptly controlled by boracic acid, which before had not succeeded. Aristol has an anodyne effect, and is a good preparatory application, but is of no further use after a single trial.—*St. Louis Med. and Surg. Jour.*, Dec., 1890.

Randall (B. A.) on Caries of the Wall of the Auditory Canal.—There is quite a group of cases in which the ear lesion is confined to the auditory canal, and investigation shows that the source of the pus is a carious area usually upon the posterior or lower wall. Most cases of polyp of the external canal are such. Of course this is not the case with polyps growing from the tympanum into the canal, nor polypoid granulations from excessive fomentation of furuncles of the canal, nor in rare cases where it may prove to be a sinus reaching into the antrum of the mastoid. The cause of the affection is not clear. It is quite possible to be due at times to a furuncle, the inflammation penetrating deeply enough to injure the bone by destroying its periosteum. The progress towards repair is almost invariably slow. Careful cleansing is the first requisite, and is best secured by the peroxide of hydrogen and a fine syringe. Laying open the carious surface and scraping it is liable to set up considerable reaction, with closure of the canal and dangerous retention of pus. The danger of the affection is small.—*Univers. Med. Mag.*, Nov., 1890.

Turnbull (L.) on the Etiology of Tinnitus.—We are now able in almost every instance to determine the cause of any form of noise in the head and ears, and by the aid of instruments refer them to the part of the head or ear to which they belong. Again, we can reduce the noises to three classes, and as soon as the patient gives the history of the form he suffers from we can classify it as: (1) The constant rushing and knocking or pulsating noises. These are the most rare, and almost always depend upon hyperæmia, venous or arterial effusion of blood, serum, or pus in labyrinth, semi-circular canals, ecchymosis in the vestibule, hyperæmia of the cochlea; extra-aural as aneurism, anæmia, chlorosis, lithæmia, temporary or permanent changes in blood-vessels in and around the ear. (2) Moist sounds of great variety depending on the patient's occupation and intelligence, but chiefly called gurgling, bubbling, boiling, singing, whistling, shell-like roaring, etc. These indicate the presence of fluid on the drum or in the cavity, catarrh of the Eustachian canal, auditory canal, mastoid cells, or post-nasal and pharyngeal spaces. (3) Dry roaring and ringing sounds, comprising a large number of diseases of the auditory nerve, direct or reflex. Among the direct, chronic non-suppurative middle-ear catarrh, affections of the muscular and nervous supply of the ear, cerebro-spinal-meningitis, pressure of tumors in or about the ear or

auditory nerve, Ménière's and syphilitic disease of the nervous apparatus of the ear. *Certain habits induce the noises.* Use of stimulants and tobaccco, a full meal, great bodily or mental fatigue, mental action with artificial light and heat near the head. Certain vocations increase the noises, as telegraph operatives, locomotive engineers, boiler-makers, machine workers in cotton or wool factories. *Mental Influences.*—A happy frame of mind, pleasant, active occupation, and riding in carriage or train, during the daytime diminish these sounds. Ill-temper, extremes of temperature, indigestion, the night with its quiet, meeting strangers, etc., increase the sounds. In women tinnitus is apt to appear with sick stomach during pregnancy and menstruation. Painful noises attend diseased kidneys, especially diabetes and Bright's. Subjective sounds in middle-ear disease can be changed by pressure with the finger on the mastoid or first cervical vertebra, and increased by closing the external meatus. In post-mortems on persons who have suffered tinnitus for long periods without any apparent disease of the ear, there has been found disease of the semi-circular canals, ecchymosis of the vestibule, hyperæmia of the cochlea, and general enlargement and fullness of the vessels of the labyrinth.—*Brit. Med. Jour.*, Sept. 20, 1890.

Cousins (J. W.) on the Value of Artificial Drumheads.—Artificial tympani do improve the hearing of many patients, and the successful forms have been composed of various materials. Their real value must be estimated by ordinary conversation. There is no standard of classification and comparison of cases. The degree of improvement can be calculated by observing: (1) The help afforded in conversation; (2) the increase in hearing distance; (3) the improved expression of the patient. The diseased condition in which artificial drums are useful is most frequently cases of perforation of the tympanum. The amount of benefit does not depend on the size of the perforation or the seat of the injury, for other conditions always exist which exert a varying influence on the result. These artificial drums are sometimes useful in chronic middle-ear disease, with ossicular changes and cicatricial collapse of the drum membrane, provided the Eustachian canal be free and the naso-pharynx fairly healthy even without any perforation of the drum. It is not necessary that the appliances should be placed over the perforations so as to fill them—in fact, it is dangerous to have them plug the opening, retaining thus the secretions and discharge of the ear. It is a matter of importance that the artificial membrane should be selected to suit the shape and capacity of the external ear. It is my practice to regulate the height of the crown of my membrane by the sensations of my patient and the width of the brim by the size of the meatus. It must not fit too tightly, but simply rest in contact with the meatal wall. In the dry forms the drum may be immediately beneficial, but in the suppurative forms removal of this condition alone can bring out the advantages of the artifice.—*Brit. Med. Jour.*, Sept. 20, 1890.

REPORT ON ORTHOPEDIC SURGERY.

BY JOHN RIDLON, M.D.

Pooley (J. H.) on Syphilitic Muscular Contractions.—Two cases are reported: one of flexion of both thighs on the pelvis and legs on the thighs; and the other of contraction of the masseter muscles. Both had been treated mechanically without result, and both recovered completely under the use of mercury and iodide of potash.

Muscular contraction is one of the rarest of syphilitic lesions, and these two cases are additionally interesting from the fact that most of the cases hitherto reported have involved the muscles of the arm.

Ricord gave an imperfect account of this condition so long ago as 1842. M. Notta, in an interesting paper on "Syphilitic Muscular Contractions," gives three cases, the features of which were much the same, and in each case the biceps was the seat of the contraction. In my cases, as in all those which have been reported as far as I know, the affection came on rather slowly. There was no tumor or swelling of the muscles involved; indeed, the intimate pathology of the condition is still unexplained. It is generally one of the late manifestations of syphilis, but sometimes makes its appearance early in the disease. It generally yields promptly to the mixed treatment or to iodide of potassium alone, but the simple administration of mercury does not affect it favorably; indeed, it is

said sometimes to have been aggravated by the use of mercury alone.—*Medical Compend.*, January, 1890.

Gillette (A. J.) on Tenotomy for Relief of Deformity in Spastic Paralysis.—The writer reports a case of cerebral hemiplegia in a child, eleven years of age, occurring when the child was twenty-six months old, with resulting talipes equinus, hammer-toes, and flexion at the knee, for which he made a subcutaneous division of the Achilles tendon. The case had been treated without relief by mechanical means during all this time. Simple division of the Achilles tendon permitted the foot to return to the normal position, completely relieving not only the equinus, but the varus and hammer-toes as well, and also the flexion at the knee. Eight months have now elapsed since the operation, and there has been no return of spasm in any of the muscles of the leg. The ankle-joint will permit of almost normal movement, and the patient walks with but a slight limp.—*Med. Record*, Oct. 4, 1890.

Gibney (V. P.) on a Contribution to the Therapeutics of Spastic Paralysis.—Four cases are reported in detail. The treatment consisted in dividing subcutaneously all tense bands and then holding the affected limbs in the desired position for some weeks.

The cases just reported are a small number of those treated in this way for several years past, and, while many fail to get the benefit that these here recorded have received, the writer is confident that many have been enabled to walk and get about without assistance. It is necessary, after dividing the tendons, to keep the feet in normal position for two or three months after the operation. The tendons are apt to lengthen, and calcaneus has in some instances resulted. The relief given to the nervous condition in many of these patients is most marked.—*Jour. Nerv. and Ment. Dis.*, Aug., 1890.

Scudder (C. L.) on a Determination of the Muscular Strength of Growing Girls and its Relation to the Etiology, Treatment, and Prognosis of Cases of Lateral Curvature of the Spine.—The writer has made an investigation to establish an index of muscular strength in growing girls, for each age from the tenth to the nineteenth year. The report is based upon an examination of one thousand and forty-one of the school girls of Boston. It was conducted by means of a chair especially constructed for the purpose; the muscular strength of the back muscles as a group being measured by a self-registering dynamometer. The results of the investigation show the gradual increase in the strength of the back muscles for the age of the growing child. The importance of this investigation, as establishing a firm scientific basis for a further study of the muscular element in the etiology, was shown, as well as its bearing upon the treatment, the prognosis, and the recording of lateral curvature cases.—*Boston Med. and Surg. Jour.*, Nov. 6, 1890.

Young (J. K.) on Torticollis as a Cause of Scoliosis.—The two cases reported present no evidence that the scoliosis was in any way dependent upon the torticollis as a cause, nor is there any thing to show that the scoliosis and the torticollis were not both due to one and the same central nerve lesion. However, our author holds that the exact process by which a cervical curvature from wry-neck induces a lateral curvature of the entire column may be interesting. The deviation of the head to one side, and the flexion of the chin upon the thorax by the unilateral contraction, induce a bowing of the cervical vertebræ to that side and rotation of the bodies upon one another. There is at once produced a characteristic alteration in the outline of the neck, the graceful double curve becomes flattened, the neck shortened, and the shoulder less prominent on the one side, while the curved line becomes more pronounced, the neck longer, and the shoulder more prominent on the other side.

The natural balance of the column being disturbed, nature endeavors, by a compensatory dorsal curve, to restore the equilibrium. This induces a rotation of the bodies of the dorsal vertebræ, with all its attendant deforming features—the flattening and twisting of the scapula on one side, the deviation of the spinous processes in a serpentine direction from the median line, and the elevation and projection backward of the scapula on the other side. With the development of a third or lumbar curve, the crest of the hip becomes obliterated on one side, the waist line deepens, the hip becomes prominent on the other side, and the lateral outlines become everywhere less symmetrical.

The contraction continuing, anatomical

changes are produced which not only tend to fix the vertebræ in their deformed relations, but also to exaggerate the abnormal curves. These changes are chiefly atrophy of the bones and intervertebral cartilages on the concave side of the curve, with shortening of the ligaments and muscles, and hypertrophy of the bone and cartilage, with elongation of the ligaments and thickening of the muscles on the other side.—*Med. Progress*, Feb. 22, 1890.

Judson (A. B.) on Mechanism of Rotation.—The author claims that rotation of the spine is a necessary accompaniment of curvature of the spine in disease and also in health. It may be seen in a thin person when the trunk takes a strong curve to the right or left, and is readily observed in the gymnasium. It is one of the normal functions of the spinal column, and adds a sinuous grace to the movements of the trunk. Its cause is found in the fact that, when the spine curves laterally, the bodies forming the anterior part of the vertebral structure are free to move laterally in the cavity of the chest and abdomen, while the processes forming the posterior part of the column are prevented from the same degree of lateral displacement by being entangled in the parietes, composed of ribs, muscles, and fasciæ.

An important effect of rotation in the deformity produced by lateral curvature is seen in the fact that the curvature is greater in the anterior part of the column than in the posterior. A slight curve in the processes means a considerable curve in the bodies, and an early diagnosis may be made by looking for rotation rather than for curvature.

Rotation may be recognized in a case of incipient lateral curvature by observing scapular obliquity and a prominence of the transverse processes on the side of the convexity. Its effects on the ribs is to produce an inequality in the diagonal diameters of the chest, as detected by palpation between the two hands. In the absence of positive knowledge of the etiology, he assumed that lateral curvature is an expression of inability on the part of the muscles (very likely of nervous origin) to hold the spine erect.

He declined to approve of braces applied for the forcible arrest or reduction of curvature. The mechanical difficulties are too great. A knee can be straightened by applying pressure from before backward in the neighborhood of the joint, and counter-pressure from behind forward at points remote from the joint on the long bony levers which compose this joint, but he would not try to straighten by pressure an upright column of a score of short bones thrown into a double or triple curvature, with the added complication of rotation at two or three points in opposite directions.

He would advise the patient to avoid fatigue from whatever cause, and to assume for as many hours in the twenty-four as is practicable those attitudes in which there is the nearest possible approach to symmetry. In this way the increment which belongs to the growing child will be on the right side of the line between symmetry and deformity. The patient should sleep supine, with lordosis produced by an air-pillow. The same position should be taken a portion of every day. Suspension should also be practised up to, but not beyond, the point of fatigue.—*Med. Record*, Nov. 1, 1890.

Taylor (H. L.) on the Treatment of Lateral Curvature.—In the absence of a scientifically observed and properly digested clinical history, and a satisfactory theory of pathology, there is no complete basis for a thoroughly rational treatment of lateral curvature. We must bear in mind that some cases have been arrested in the milder stage without treatment; others, however, and probably the majority of those brought to the surgeon, have a decided tendency to grow worse. In the milder stages of the affection, general and special hygienic and tonic measures should be adopted, and all the mental and bodily activities adjusted with a view to eliminating deleterious influences and invigorating the system. There is an undue proportion of the overtaxed, precocious, and intense type among these children, and careful investigation will often reveal mental, emotional, or physical over-strain in some direction. In general, the school work will need regulation as to manner or quantity; piano practice should be reduced to a minimum or abolished, and any thing that tends to pervert the storage of force or to disturb the equilibrium of the nervous system should be corrected. Habits of regularity in eating, exercise, and sleeping should be introduced, and moderate exercise, with stated rests in the daytime and plenty of fresh air should be insisted upon. The particular indications vary in the indi-

vidual cases, but, when seen early, these measures are usually successful. If our recorded observations show that the patient is growing worse, we use, in addition, carefully regulated special exercises, some of them passive and given by means of apparatus driven by steam-power. These favor correction of the deformity, increase of flexibility in the stiffened regions of the spine, and improvement of circulation and nutrition, muscular tone, and general vigor. By these means we nearly always succeed in improving the general health, and frequently the carriage and figure of the patient, by the increased tone and buoyancy of the system. While active and postural exercises are undoubtedly beneficial, if used with judgment, we should avoid taxing the patient by a too strenuous insistance on them.

In many instances, in addition to these measures, the back will require mechanical support, which we furnish by an apparatus on the principle of lateral leverage, and adapt to the requirements of the case in hand, but only when the co-operation of the patient enables us to carry the case progressively forward by frequent manipulations of the apparatus to produce certain definite results; and thus, in properly selected cases, mechanical support has been a great aid.—*N. Y. Med. Jour.*, Nov. 15, 1890.

Martin (E.) on Pott's Disease Treated by Continued Extension.—The disease was located at the eleventh and twelfth dorsal and first lumbar vertebræ. Traction was made from a plaster jacket, by a cord passing to the head of the bed, and a weight of thirty-six pounds. The patient, who could not walk when the treatment was commenced, is reported cured at the end of five months.—*University Med. Mag.*, Nov., 1890.

Battle (W. H.) on Hip Disease.—The writer reports a case of hip disease with abscess. The abscess was opened and excised, the bone focus in the neck of the femur was scraped out, and closed, without drainage, by primary union. A perfectly movable joint was obtained.—*Brit. Med. Jour.*, Oct. 18, 1890.

Young (J. K.) on Pott's Disease of the Spine.—While this paper contains nothing of a new or novel nature, it is a very careful *résumé* of our present knowledge of Pott's disease, considering frequency, ætiology, pathology, symptomatology, diagnosis, progress, prognosis, and treatment, with abundant references to modern writers on the subject. The paper is so well worth perusal as a whole that an abstract will not be attempted.—*Med. Age*, Nov. 10, 1890.

Phelps (A. M.) on the Plaster-of-Paris Portable Bed, Used in the Treatment of Disease of the Hip-Joint and Pott's Disease of the Spine in Children.—A board is cut to correspond to the length and two thirds of the width of the child. This is carefully padded. The child is now laid on the board and enveloped with a plaster-of-Paris bandage from the feet to the axilla, to a thickness of three eighths of an inch. When the plaster is set, the front is cut away. This bed can now be lined and a front put on it and lacings put in, or the child can be held in place by means of bandages. As the plaster bandages are rolled on, they should be nailed to the edges of the board, thus making the board and plaster one. This bed will be found to fit better, be lighter, and more convenient to make than the wood cuirass. Extension in hip-joint disease is made to the foot-piece, and lateral extension by cutting away the side a little and putting in a staple, to which the bandage is tied.

The portable bed possesses nothing superior to the wire cuirass to recommend it only its cheapness, costing, as it does, about three dollars; and then a skilled mechanic is not required; any practitioner would be equal to the task. This will enable the mother or nurse to carry the child about, and the hip-joint or spine is perfectly immobilized by fixation. In hip-joint disease the bed restricts the normal movements of the joint. The lateral extension, combined with the longitudinal, makes traction upon the joint in a line corresponding to the axis of the neck of the femur.—*New Eng. Med. Monthly*, Nov., 1890.

Baker (A. E.) on Seven Cases of Excision of the Hip, Combined with the Hot-Water Flushing Method; Primary Union in Six.—The paper was intended to be the sequel to a paper read before the Society on November 11, 1888, on "Primary Union after Excision of Tubercular Hip-Joints." All the cases operated on by the author by the same method since then were now recorded, and a table was given showing the results of all. In

every case advanced disease with abscess was present, prolonged lest having failed, and all the usual means having been exhausted to prevent the development of the latter. "The merit of the *technique* employed in these cases was that the evacuation" of the tuberculous material was "made so thoroughly that it was safe to close up the wound on the spot without drainage, and look for union everywhere in the structures left behind, a sound cicatricial tissue taking the place of the diseased area, and all open sinuses being prevented." One of the cases in the series ought not properly to be included in the latter, the conditions under which this method of procedure was recommended having been violated. It served, however, to illustrate the limits which might be set to the method in question, and was therefore included in the list. It was the only case out of the six in which sound healing by first intention without drainage did not take place, although otherwise the patient did well. All the others healed under the first dressing applied on the operating table, and had remained sound ever since. The method of procedure was briefly sketched, and the most important details were indicated. The principle underlying it was simply to get rid of all the diseased tissue in the joint which had already degenerated and broken down, and to do this in such a thorough manner by flushing and gouging combined that the tissues left left behind were capable of uniting at once by first intention. The necessity of a continuance of the perfect immobilization previously in force was then insisted upon, and it was recommended that this should be kept up probably for some four or five months after the operation before the patient was allowed to walk.—*Brit. Med. Jour.*, Nov. 1, 1890.

Phelps (A. M.) on Some New Lateral-Traction Hip-Splints.— My observations lead me to believe that the most serious element of destruction in hip-joint disease is the trauma and pressure produced by the spasm of the muscle; that fixation of the joint without extension is an impossibility; that the successful treatment of the joint must depend upon its absolute immobilization, which can only be produced by proper extension and fixation; that the constitutional treatment of hip-joint disease amounts to but little, independent of mechanical treatment; that mechanics are every thing; that extension in a line with the axis of the shaft and deformity alone, in hip-joint disease, is entirely wrong; that extension should be made in a line parallel to the axis of the neck—in other words, two lines of extension—otherwise the idea of extension is not perfectly carried out; that ankylosis of the joint is not produced by immobilization, but by the severity and character of the inflammation; that the long traction hip-splints in general use neither properly extend nor immobilize the joint; that the intra-articular pressure results in the destruction of the joint or anchylosis in a large percentage of cases is proved by statistics; that the results in hip-joint disease should be as good as those of knee-joint disease, and will be, provided perfect immobilization can be carried out; that patients should never be allowed to step upon any portative apparatus; that a high shoe on the well leg and crutches should be insisted upon until the patient is cured; finally, that the angular deformity seen in cured cases should not occur, and such cases are a standing rebuke to the splint and methods employed. In other words, no patient with hip-joint disease need ever recover with angular deformity. In exceptional neglected cases of dislocation a slight amount of deformity had better be left than resort to osteotomy.—*N. Y. Med. Jour.*, Nov. 8, 1890.

Whitman (H. T.) on the Best Treatment of Hip-Joint Disease among Chinese Patients.—After discussing the various plans of treatment in use here and in Europe, the writer concludes:

To sum up this subject, I am inclined to view it as follows: (1) That the most advanced treatment of hip-joint disease at present should include modifications of the three methods referred to in this paper, *i. e.*, primarily the mechanical with the constitutional, but resort to excision if other means fail or the patient is seen too late to employ the mechanical method. (2) That the mechanical treatment should employ that kind of apparatus which will secure double extension and fixation in order to prevent traumatism and furnish absolute immobility to the joint. (3) That in the first stage of the disease, if the inflammation is slight, the treatment may admit of out-door exercise, but when the inflammation is considerable, the patient should be con-

fined to a recumbent position. (4) That, owing to the peculiar conditions existing in China, it is practically impossible to apply the best methods which scientific medicine calls for. (5) That in China the main reliance must be upon constitutional treatment, but use the mechanical method whenever an opportunity offers and, as a rule, perform excision as often as consent can be obtained after the stage for mechanical treatment has passed. And (6) that, in the large majority of cases, the ultimate results, from any or all methods, are unsatisfactory from a scientific point of view.—*China Med. Miss. Jour.*, Sept. 1, 1890.

Bauer (L.) on a Study of the Nature and Causation of Inflammatory and Suppurative Bone and Joint Diseases.—After reviewing much German literature on the bacillary theory of bone and joint affections, which views the writer questions, he submits the following theses:

1. Modern writers on the subject admit promiscuous accidents and injuries to the skeleton during childhood, but consider them harmless unless they find the constitution fully prepared with pathogenetic elements. In other words, the injury means nothing, the constitutional vitiation every thing.

2. Thus the disease is engendered, and gradually develops to dangerous proportions. As long as the patient is free from pain, no measures are taken to intercept the growing trouble. When the pain or deformity become a disturber of comfort, then and not until then is the disease taken notice of, and pronounced tubercular, according to the modern theory.

3. The physician is as helpless against the symptoms caused by assumed scrofulosis as by assumed tuberculosis. All he can do to improve the constitution is by surrounding the patient with hygienic and dietetic advantages.

4. In reference to the local affection, the same remedies are resorted to which modern surgery has introduced and demonstrated, by stubborn clinical facts, to be beneficial, effective, and even curative.

5. The benefits derived from the exclusively local and mechanical means, suggest that only local diseases can be thus overcome. Nevertheless, this suggestive logic is ignored, and another one, ætiology based exclusively on theory and arbitrary speculation, is put in its place.

6. When this tubercular affection is taken hold of, rest and position enforced, the troubles ameliorate at once; become gradually repressed, and in a good percentage of cases full repair and recovery ensue. The logical inference suggests:

a. The strictly local origin of the disease which has yielded to exclusive local treatment.

b. If rest and position alone are so effective in the reconstruction of healthy structures, it seems to be very conclusive that motion constitutes a propelling factor in the advancement of the former disease.

7. It is held by the bacteriologists that the parasites must be transmitted by heredity, or acquired *per vias naturales* or wounds. Before the bacillus can assert its specific mischief it must become a part and parcel of the constitution, and thus enjoy free admission to all parts of the body. As already stated, the bacillus is supposed to pre-exist before an injury is inflicted, then it rushes to the traumatized locality and commences its pathological devastations. This is the train of prevailing opinion.

8. After the bacillus tuberculosis has acquired firm hold of the constitution and the local focus has succeeded in producing an unknown quantity of ptomaines or toxine, a surgeon is put in requisition, and he exsects the entire morbid structure, and the patient recovers.

9. The followers of Koch contend that the *locus minoris resistentiæ* was removed and the patient recovered, but they lost sight of two things:

a. That the constitutional invasion of the bacillus remains unchanged, and

b. That for the old *locus minoris resistentiæ* a new one has been created by the operation. Notwithstanding that the patient recovered, the theory of constitutional causation is upheld in the face of contradictory facts.

10. Assuming a case of Pott's disease, spondylitis has preceded caries of vertebral bodies. The matter forming descends to the groin along the aponeurosis of the psoas major. In the vicinity of the small trochanter an abscess is formed and growing. The disease of the spine is of course tubercular! So is the pus of the consecutive abscess. By proper treatment in the recumbent posture, the local disturbance is somewhat ameliorated, and the supply of pus to the reservoir lessened. Resorption diminishes the purulent collection. Fatty

degeneration of the pus cells prevails, and the once large mass shrinks to a cheesy remnant, which may eventually be squeezed out through the spontaneous softening of the integument. These are facts, presenting themselves to the observation of physicians.

11. If the patient was invaded by the tubercular bacillus; if the bacillus availed itself of a *locus minoris resistentiæ;* if this *locus minoris resistentiæ* was gradually obliterated by proper treatment; if the pus formed at the spine, together with the bacilli, escaped into new quarters, and failing to improve by the opportunity, the pus evaporates, the bacillus goes into hibernation, and the patient gradually gets well—what becomes of the bacilli located in the original focus? What of the bacilli which remain in the constitution? What of the bacillus in the psoas abscess?

Verily, the bacillus is not as tyrannical and dangerous to the constitution as its admirers would have it.

12. Has it been absolutely proven that microbes are not scavengers merely?—*No.-Western Lancet*, Oct. 15, 1890.

Ransohoff (J.) on Tuberculous Disease of the Tarsus.—The writer discusses the operative aspects in tarsal disease for the following reasons: (1) because in no other portion of the skeleton, with the possible exception of the wrist, is disease so liable to spread from part to part, assuming a progressive type and generally terminating only after a number of years with partial or complete loss of the affected parts; (2) because in tarsal disease the influence of age on the progress and termination of tuberculosis of bone finds an excellent illustration; and (3) because in disease of no other part of the skeleton are the questions of how and when to operate, if operation be at all desirable, more difficult to answer.

From a study of the cases tabulated he concludes: Although the number of cases here tabulated is not large, a few deductions can be made. Of 30 operations made for tarsal disease there were 15 of *évidement*, of which but 2 were successful, and these were children. In 6 the curetting was followed by an exacerbation of the previous difficulty. Of the 12 excisions, 4 were primary, and in 3 the operations were made before sinuses had formed. In these primary operations the repair was more rapid than in those in which curetting had previously been done. Four of the excisions were failures, in 3 from recurrence of the disease, and in the fourth from the uselessness of the foot. While no deaths were directly attributable to tarsal disease, death resulted in 2 of the cases from general tuberculosis, which might have been avoided by a primary excision, or more certainly by early amputation.—*Med. News*, Nov. 29, 1890.

Van Hook (W.) on the Diagnosis of Congenital Dislocation of the Hip-Joint.—But, once the child attempts to walk (and the child usually creeps much longer than other children) the peculiar waddling, "goose-like" gait calls attention to the local difficulty. The patient is observed to have a lumbar curve so exaggerated as to amount to *lordosis*, but this curvature decreases to the normal degree when the patient lies down.

The head of the femur (when the head is not atrophied) can be felt in its abnormal position when one hand is laid over the ilium and the femur is rotated upon its axis with the other. This abnormal position of the femoral head can be best demonstrated by drawing the imaginary line of Nélaton and Roser from the anterior upper iliac spine to the ischial tuberosity. Normally this line passes immediately over the centre of the trochanter major. In congenital dislocations upon the dorsum ilii the trochanter is found one, two, or even three inches above this line. Easily distinguishing the congenital from the acquired dislocations, the head may be readily brought back by traction into the normal position. The force removed, however, the deformity immediately recurs.

Motion at the hip-joint is abnormally free, indeed adduction and inward rotation are abnormally so. Adduction and outward rotation may be restricted slightly, unless the head and neck of the femur are absorbed or greatly atrophied (Stedman).—*N. Amer. Pract.*, Nov., 1890.

Milliken (F. H.) on Treatment of Infantile Club-Foot Preliminary to Operation.—The writer holds that tenotomy and osteotomy are too frequently performed on infants two or three months old. This is premature practice, and in general is attended by disadvantages, because, as they do not walk, they do not use their muscles, and relapse may occur. If a relapse does occur it is not easily remedied. He would delay all cutting operations until

the time when the child might be expected to walk. He advises manipulating the foot from ten to twenty times a day, massage, the faradic current, mechanical means, and plaster-of-Paris running above the knee.—*Med. News*, Nov. 22, 1890.

Tompkins (E. L.) on the Dangers of Excessive Physical Exercise.—The word exercise, in its physiological sense, means that quantity of activity of every anatomical part of the body which will require that part to perform its function. The popular definition of exercise at the present time is contraction of the voluntary muscles. That is perfectly proper, if taken with moderation, but nothing seems of interest now unless in competition with some one else. The author has endeavored to separate the dangers of excessive exercise into four divisions, viz., the danger to the brain, to the heart, to the lungs, and muscular system.

These are each considered in detail, and strong conclusions are drawn against the tendencies of athletics to feats of strength and endurance.—*N. Y. Med. Jour.*, Nov. 29, 1890.

Sargent (D. A.) on the Physical Proportions of the Typical Man.—Prof. D. A. Sargent, M.D., Director of the Hemenway Gymnasium, Harvard University, has recently awarded the prizes which he offered three years ago for the highest standards of physical development.

For many years, and especially since 1879, when he was made director of the Hemenway Gymnasium, Dr. Sargent has been collecting anthrometric data. In 1886, having gathered from various gymnasiums a large number of measurements of men and women, he was able to establish an extensive scheme of standards and percentages, and to compute what he called percentile tables.

In a contribution to *Scribner's Magazine* for July, 1887, under this title, he explained the object of this chart as being to furnish the youth of both sexes with a laudable incentive to systematic and judicious physical training, by showing them their relation in size, strength, symmetry, and development to the normal standard.

The percentile values are relative, and not absolute. These depend not upon any arbitrary standard, but upon the total number and character of the measurements taken. Each measurement of an individual is compared with the corresponding measurement of the thousands already taken and tabulated, and its relative position given to it upon the chart. Perfect symmetry, according to Dr. Sargent's method, is shown by the exact correspondence of the percentile values of all the various measurements of an individual. In this case the line of symmetry would be straight.

The *Boston Medical and Surgical Journal* well remarks: "The correctness of this principle of estimating physical excellence will appeal to each individual according as he admits, or not, the correspondence of the ideal human form with the average human form as determined by such measurements.—*The Sanitarian*, Oct., 1890.

REPORTS ON OBSTETRICS AND DISEASES OF CHILDREN.

BY ELIZABETH STOW BROWN, M.D.

Dixon (Arch.) on Arrest of Evolution versus Maternal Impressions.—The present article was brought out by a recent paper of Dr. Fordyce Barker, and one later of Dr. T. B Greenley, of Kentucky. Both of these gentlemen maintain that mental impressions upon the mother are conveyed to the fœtus in utero, and are the cause of monstrosities, amputations, nævi, and other abnormalities. None of the eminent advocates of this theory claim that the effects are brought about otherwise than through the medium of the blood, which in some way conveys the influence of the existing condition of the mother to the fœtus by the interchange of circulation. The author thinks that the evidence for this theory is far from conclusive, and that it can be successfully refuted by the proof of demonstrated pathological, physiological, and embryological truth, which undoubtedly reveals that all of these so-called maternal impressions, monstrosities, marks, etc., are the results of arrest of development or evolution, pressure by amniotic bands, pressure by the umbilical cord, adhesion of the placenta, or by some pathological condition of the fœtus or its membranes, or by heredity.

The influences and facts to be drawn from a careful review of the evidences are :

a. That during the embryonic existence certain parts may be hindered or arrested in their development, while the other organs not directly connected with them may continue their evolution and become fully developed.

b. That ectopia viscera of the abdomen, spina bifida, cleft palate, hare-lip, webbed fingers and toes, etc., are only evidence of arrested development of embryonic abdominal, spinal, and maxillary processes, or in the case of webbed extremities, the continuation of the embryonic hand or foot of the second month.

c. That any agency causing arrest of development of any portion of the fœtus must necessarily operate prior to the evolution of the part.

d. That the cause of the arrested development may be local or general, as injuries to mother's abdomen, diseases of the uterus or its membranes, hereditary transmission of deformity.

e. That excessive development of parts of the fœtus may obtain, resulting in nævi, aneurisms by anastomosis, supernumerary fingers and toes, etc.

f. That intra-uterine amputations are the result of amniotic bands, placental adhesions, fracture, or from constriction by a loop of the umbilical cord.

g. That amniotic bands or placental adhesions result from inflammation of the uterus, its decidua, or inflammatory diseases of the fœtus.

h. That the false membranes causing these amputations may be afterward absorbed, as also the amputated extremity.

i. That so-called double monsters are the result of the development a double cicatricula on the blastodermic membrane of a single ovum.

j. That twins with a common chorion also result from the development of a double cicatricula on the blastodermic membrane of a single ovum.

k. That in either case there is always unity of sex.

l. That the nearness of the primitive traces to each other determines whether the impregnation will result in separate twins or a double monster.

m. That in twins with single chorion or anastomosis of placental vessels, one fœtus may become perfectly formed while the other becomes monstrous.

n. That the development of the abnormality in such cases depends on local anatomical causes, and is governed by definite laws.

o. That every known form of malformation in the human race has its analogue in the lower animals, birds, fishes, and reptiles.

p. That arrest of development at any of the stages of embryonic life results, in part or in whole, in a permanent embryo of the stage at which the arrest took place. — *Western Med. Reporter*, Nov., 1890.

Cameron (J. C.) upon the Influence of Leukæmia upon Pregnancy and Labor.—Three years ago, at the Washington Congress, Dr. Cameron read a paper upon the influence of leukæmia upon pregnancy and labor, and gave a series of observations upon a patient who, while undoubtedly leukæmic, had passed safely through two pregnancies, borne two living children, and was, at the time, again well advanced in pregnancy. Cases had been observed where leukæmia seemed to begin during or as the result of pregnancy; but up to that time none had been recorded where a woman already leukæmic had become pregnant and borne a living child. By this case of the author it seemed to be clearly proven that a leukæmic mother may bear a non-leukæmic child, and that consequently the fœtal and maternal circulations are separate and distinct, and the placental barricade impervious to leucocytes. It seemed also proven that leukæmic symptoms are aggravated during the course of pregnancy but subside rapidly after its conclusion, and that leukæmia does not necessarily prevent conception or even limit the frequency of its occurrence. Since the Washington Congress several new cases have been reported which throw fresh light upon the subject.

Several cases are described, and the careful examinations of the blood recorded.

From the observations now on record the following conclusions seem to be justified :

1. A leukæmic mother may go to full term and bear a healthy child.

2. Leukæmia tends to bring on labor prematurely or reduce the patient to such a critical state that the premature induction of labor becomes advisable.

3. Leukæmia in pregnant women tends to run a rapidly fatal course ; yet occa-

sionally its progress may be slow, though progressive.

4. During the first three or four months of gestation, a leukæmic patient may not suffer much inconvenience; but as intra-abdominal tension increases, her distress becomes greater, grave symptoms rapidly develop, and the patient is quickly reduced to a pitiable and dangerous condition.

5. Leukæmia does not prevent the occurrence of pregnancy, nor does it seem to limit its frequency.

6. As regards the relative characters of blood in the maternal, fœtal, and placental circulation, later observations confirm those made on a previous occasion.

7. While epistaxis, hæmatemesis, and melæna may occur frequently during the progress of gestation, there may be no uterine hemorrhage at the time of labor or during the puerperium.

8. Menstruation may be affected. In the case recorded, menstruation was scanty and painless before the appearance of leukæmia; since, it has been profuse and painful.

9. Leukæmia seems sometimes to have an injurious effect upon lactation. In the case recorded, who had always been a good nurse, the function was either suppressed or the milk so altered in quality as to become unwholesome and injurious.

10. The question of hereditary influence or predisposition is unsettled, but this case is very suggestive. The grandmother, mother, and brother suffered from symptoms pointing to leukæmia; two of her own children have had undoubted leukæmia, all have had jaundice, most are subject to epistaxis, all have glandular enlargement and more or less anæmia. It is more than probable that some of these children will sooner or later develop leukæmia. One child at least, born before her mother showed signs of leukæmia, suffered from well-marked leukæmia lienalis. Although a mother does not transmit leukæmia directly to her child, is it not very probable that she may transmit a tendency or predisposition thereto?—*Am. Jour. of Med. Sci.*, Nov., 1890.

Seibert (A.) on the Use of Alcohol in the Treatment of the Diseases of Children.—The chief action of alcohol on the human body, if given in moderate doses, is a stimulating one, and favorably influences the nervous system, the circulation, and the digestion.

The author proceeds to answer the questions:

1. When shall we give alcohol in the diseases of children?

2. How shall we administer alcohol?

He thinks that alcohol should be used whenever danger threatens from insufficiency of the heart muscles, and depression of the nerve-centres, especially in acute infectious diseases, in which the blood and other tissues are invaded by pathogenic organisms. Alcohol should never be used in affections of the stomach, and never whenever it is still possible to nourish the patient. Alcohol is a substitute for nourishment, but not its promoter. The writer never uses alcohol in acute cases (diphtheria, scarlatina, and typhoid) as long as digestion is possible. In chronic cases he never uses alcohol in any form, tuberculosis excepted. He also excludes all forms of gastro-intestinal disturbances in infants from the list of diseases where alcohol is beneficial. As to how alcohol shall be administered, the author prefers rye whiskey to any thing else. The child may be bathed with it, or it may be given in some gruel by an enema into the bowel. Occasionally wine may be found necessary. The sweet Hungarian Tokay wines are certainly very palatable, but interfere still more with stomach digestion than whiskey, on account of the large quantity of sugar or glucose they contain.

As to the time of giving alcohol, it is recommended to begin early in infectious troubles, gradually increasing the dose. When the blood seems the chief region for the action of the disease-germs, there should be administration of frequent large quantities of alcohol.

In summing up, the writer states that, generally speaking, alcohol should only be used as a stimulant in acute infectious diseases of children, and then in large quantities, and, if possible, should never enter the body through the stomach.—*Arch. of Ped.*, Dec., 1890.

Winters (Joseph E.) on the Use of Alcohol in the Treatment of the Diseases of Children. — In thinking over what rules have guided him in the use of stimulants in diseases of children, the author concludes that his most important rule is that we must individualize, each case must be treated for itself. He finds that in practice it is necessary to make a very great distinction according to whether

the alcohol is intended to affect the heart and circulation, or whether it is intended to act indirectly as a tonic. In the first place, it is used as a heart-stimulant to tide over an emergency, especially in pulmonary diseases. In the second, we wish to stimulate the secretions, promote digestion and assimilation, and aid other drugs in these directions. Stimulants are used for this purpose during convalescence from acute diseases. In pulmonary affections it is recommended to use a great deal of alcohol in combination with extract of malt and cod-liver oil. By the use of two parts of malt extract and cod-liver oil, and one part of whiskey, given in drachm doses every two hours, a valuable tonic effect is obtained during convalescence from acute disease in children, especially bronchitis and broncho-pneumonia.

The writer thinks alcohol is scarcely ever called for in acute lobar pneumonia of childhood as a heart-stimulant. In broncho-pneumonia he does not use it, as a rule, until the inflammatory stage has pretty well passed. But in pulmonary affections, in which the superficial veins become full, accompanied by cyanosis, alcohol should be used early and constantly. Whenever, in the course of a broncho-pneumonia, the symptoms appear to be improving, the cough loosened and much less distressing, but on examination the physical signs in the chest are found persisting or increasing, alcohol is indicated, and in full doses. In any case of acute disease where there is very great restlessness, and sedatives fail to soothe and quiet, alcohol, as a rule, will have that effect. But in this use of alcohol it is the temperament of the patient and not the disease that is treated. Where there is delirium, or restlessness and tendency to local spasm, with injection of the conjunctival vessels, alcohol is harmful. When during the use of alcohol, in the course of an acute disease, vomiting has come on, often it will not cease till the alcohol is discontinued. The author has found that, in giving stimulants to children, champagne scarcely ever agrees as well as it does with adults.—*Arch. of Ped.*, Dec., 1890.

Holt (L. Emmett) upon the Capacity of the Stomach in Infancy.—"The subject of the quantity of food to be allowed to artificially fed infants is second in importance only to the character and preparation of the food given. It is only within very recent times that this factor in the problem has been deemed worthy of much consideration.

"So many contradictory statements have been made by different writers, with regard to the capacity and growth of the stomach in infancy, that it has seemed worth while that this point should be made the subject of a special investigation.

"Sound knowledge in this direction will certainly bring us a little nearer the solution of the difficult problem of deciding how much an infant, of a given age, is to be fed."

Methods employed.—The observations recorded were made at autopsy. The walls of stomachs are found at autopsy in conditions widely differing from each other; sometimes very flabby and altogether relaxed, containing food in larger or smaller amount; sometimes so tightly contracted that the cavity is almost obliterated. The writer gives the details of a technique which he employed, and which obviated these difficulties.

Results.—The capacity of the stomach was measured in one hundred and forty-two infants. Thirty of the earlier cases were not included in the tables, as the method of measuring was found later to have not been quite trustworthy. Of the remaining one hundred and twelve cases, seventeen were over fourteen months old, and distributed through quite a range of months.

One chart shows the age and capacity of stomach in ninety-five infants, capacity being measured in ounces. Another chart shows the average capacity of the stomach in ninety-one cases. A general statement of the facts thus brought out shows:

1. That, starting at birth with a capacity of about one ounce, the stomach increases in size at the rate of one ounce a month during the first three months, reaching at this time about one half the capacity seen at one year.

2. From then to eight months its growth is much slower, being, on the average, about half an ounce a month.

3. From eight to fourteen months the rate of growth is still less, being, on the average, about one third of an ounce a month. Approximately *at the ages of one, three, six, and fourteen months the capacity is respectively one, four and a half, six, and nine ounces.* In short, that there is a fairly

constant relation between the age of the infant and the capacity of the stomach. If this capacity be taken as a guide to the amount of food to be allowed to an average infant in health, it cannot be far wrong. —*Arch. of Ped.*, Dec., 1890.

Loeffler (Prof. F.) on the Prophylaxis of Diphtheria.—At the International Medical Congress, Prof. Loeffler, who first isolated and cultivated the Klebs diphtheria bacillus, read a paper with the above title.

The usual rigid isolation and disinfection were insisted upon, and the question discussed of "How long can a patient furnish infectious excretions?" The author gives a case in practice where bacteriological examinations were made daily, and excretions found still infectious nearly three weeks after temperature returned to normal. For the differentiation of diphtheria from other throat affections nothing is conclusive but bacteriological examination; all doubtful cases should be reported as diphtheria until the diagnosis is clear. Epidemiologically, a case is cited where a family was taken with diphtheria a year after the house had been fumigated—"of course only with sulphur." Pieces of membrane yielded cultures in fourteen weeks, none in sixteen weeks.

The following twelve points conclude this excellent paper:

1. The bacillus found in excretions of diseased mucous membranes is the cause of diphtheria.

2. Bacillus is disseminated by excretions deposited on articles within reach of patient.

3. Viable bacilli remain several days after disappearance of membrane.

4. Patient should be strictly isolated as long as bacilli remain in excretions. Children should remain from school at least four weeks.

5. Bacilli are viable in fragments of dried membrane for four or five months. Every article in room should therefore be either boiled in water or subjected to a current of steam at 212° F.; floors to be scrubbed repeatedly with 1:1000 bichloride solution; walls and furniture rubbed down with bread.

6. Researches on viability of bacilli in moist state are not yet completed; damp rooms should be thoroughly dried, and a flood of light admitted before they are used again.

7. Bacilli still grow at 68° F.; they grow readily in milk. The sale of milk from dairies in which diphtheria abounds should be prohibited.

8. Diphtheroid diseases of various animals are not caused by bacilli of human diphtheria. Diphtheroid diseases of animals are not to be feared as sources of diphtheria in man.

9. Observations of Klein, on etiological identity of the cat disease with diphtheria in man, are not proof, and need further corroboration.

10. Lesions of mucous membrane favor the adhesion of diphtheritic virus. Susceptible individuals may, however, be infected without these lesions.

11. During prevalence of diphtheria the mouths and throats of children must be kept especially clean. Gargles and mouth washes of aromatic waters and weak bichloride solutions (1:10,000) should be used as a preventive.

12. Meteorological factors influencing development of diphtheria favorably are not known to exist.—Tr. by Wm. Krauss, *Memphis Jour. Med. Sci.*, Nov., 1890.

MISCELLANY.

Engelmann on the Causes of Ill-Health in American Girls and the Importance of Female Hygiene.—The author shows that the health of the American girl is threatened and impaired by causes more or less avoidable, as they are due to our methods of life, our methods of training and education; that the physique of this girl, most favorably situated amid auspicious possibilities, is imperfect; her brain overworked, her nerve power exhausted, her function impaired, and reproduction endangered, all by reason of the susceptibility of her peculiar organization, and the increased impressionability of the sensitive system during the years of development, in which it is subjected to the most severe strain.

The remedy is attention to woman's peculiar organization and the cyclical waves of her dominant function, or, in other words, harmonious development and occupation of nerve and muscle; diminished brain-work and nerve stimulation with increased and co-ordinate physical exercise; increased protection and diminished compression of dress; self-knowledge and

individual care during periods of heightened susceptibility. Changes are necessary in custom and fashion, in methods of labor and education. A harmonious coeducation of mind and body should be approximated.

Dr. Engelmann closes with a plea for the self-care of the American girl and her proper physiological instruction by the mother, which, alone, will mitigate or remove the initial cause of many of her ailments. Upon the mother he would impress that the perfect development of the female function, and the maintenance of this function, once developed, in a healthy condition, is essential to the perfect development of the girl and the perfect health of the woman; that self-care, a well-regulated female hygiene, is the foundation of her well-being.—*Boston Med. and Surg. Jour.*, Dec. 4, 1890.

A Laryngological Curiosity.—At a recent meeting of laryngologists in London, Mr. Lennox Browne related the case of a middle-aged woman who was sent to him from the provinces for the purpose of deciding whether her malady was laryngeal cancer or phthisis. Though a tall, large-boned woman, she only weighed a little over ninety pounds, and was obviously very much emaciated. He peeped down her larynx and to his surprise (we presume) saw what he recognized to be a plate with artificial teeth firmly impacted in the larynx, where it had been for the last twenty-two months unbeknown to the patient. She remembered having been awakened in the middle of the night by a violent fit of vomiting, and when the teeth were inquired after it was assumed that they had been thrown away with the dejections. From that day forth, however, she suffered from difficulty in breathing, pain on swallowing, etc., associated with progressive emaciation. With some difficulty the plate was removed and exhibited to the admiring friends, and the patient rapidly recovered health and spirits.—*Med. Press*, Dec. 3, 1890.

Vickery (H. F.) on Menorrhagia in a Patient Afflicted with Hæmophilia.—Miss E. M., a single woman, twenty-four years old, born in Russia, now lives in Boston, and works as a "stripper" in a cigar manufactory. She is on her feet very little. The family history is fairly good, and no relatives are known to have had symptoms like her own.

Since childhood she has been subject to the eruption of purpuric spots on the arms and legs, especially the latter. She has also had frequent nose-bleed, once or twice profuse; for instance, last winter an epistaxis lasted three days, so that a physician was summoned to check it. Since the menses began, in her fifteenth year, the nose-bleed has sometimes accompanied them. The catamenia have been regular and not excessive, although lasting five to seven days.

August 3, 1890, the regular monthly flow appeared, but it stopped in three days, a shorter time than usual. On August 27th, flowing recommenced and gradually became alarming. It was for this that I was asked to see her by her physician, Dr. B. Lecherzack, of Boston, on September 9th. The patient had kept at work till three days before. I found her weak, and with a small and rapid pulse. Purpuric spots were abundant. The possibility that her condition was due to an abortion was considered, but there were no physical signs of recent pregnancy, nor any reason to believe that pregnancy had been possible. Hot-water douches mitigated the hemorrhage, but it seemed best for the girl to enter the Massachusetts General Hospital, where she came under the care of Dr. W. W. Gannett, who has kindly consented to my publishing the case.

On the 17th of September, she was up and dressed; and on the next day the already scanty flow entirely ceased, having lasted three weeks.

Dr. Gannett found that pinching the skin would readily produce an ecchymosis.

A brief report of the above seemed justifiable, because hæmophilia is comparatively rare in women, and even when present seldom affects the menstrual flow. —*Boston Med. and Surg. Jour.*, Nov. 27, 1890.

A Courageous Departure.—When alluding to one or other of the too frequent cases of charges against medical men by female patients, we ventured to advise that it was, strictly speaking, the duty of the practitioner asked to perform an illegal operation, to denounce the person inciting him to break the law. Neither rule of etiquette nor moral law protects her who deliberately and knowingly tries to make a medical man deviate from his duty to

the profession, of which he is a member, and to the public, of the health of which he is the guardian. We, however, hardly expected that the average medical man would have the courage to act up to this interpretation of his duty. It has been reserved for one who, according to the newspaper report, is "qualified by examination although not registered," in the person of a Mr. Davenport, practising at Churton Street, Pimlico, who last week charged "a respectable married woman from Sligo, Ireland," with inciting him to commit an unlawful operation upon herself. The defendant called on Mr. Davenport, representing that she had been recommended to him by a friend, and offered a fee of three pounds for the service required. The prisoner was remanded for inquiries to be made, and it would obviously be out of place to comment on the case as it at present stands.—*Med. Press*, Dec. 3, 1890.

Herman (G. E.) on Amenorrhœa, with Mental Depression and from Mental Shock.—Some depression of spirits occurs in most conditions of debility, and is not peculiar to those which produce amenorrhœa. But in most cases of amenorrhœa, dependent upon chlorosis, wasting diseases, etc., the mental depression, although present, is not the chief symptom. Cases of pronounced melancholia are frequent enough in asylums. Between these extremes we find cases such as I have related. Other conditions much less common and less important are dwelt upon at greater length in text-books; and what is more important is that the student does not get clear and unanimous guidance as to the treatment. Should the uterus be treated? If the amenorrhœa be the cause of the symptoms it would seem rational treatment to try to stimulate the uterus to activity. But firstly, this group of symptoms often occurs in patients in whom treatment of the uterus cannot be carried out without doing them harm, even should the treatment be effective for the purpose aimed at. Secondly, I can see no good reason for expecting benefit from making the uterus bleed. Cases are common in which menstruation is absent without producing any kind of disturbance of health; and I see no reason for supposing that in these particular cases the suspension of the function should have a different result. The symptoms form a group, all connected together, just as are the symptoms of chlorosis, of phthisis, or of exophthalmic goitre. The absence of menstruation is simply part of a constitutional state. Thirdly, there is no kind of local treatment that will establish menstruation. It is easy by treatment to make the uterus bleed; but uterine hemorrhage is not menstruation. It is possible to carry out local treatment on patients who in consequence of treatment of other kinds, or of the recuperative force of nature, are getting well; and in such cases it may seem as if the re-establishment of menstruation were due to local treatment. But there is no treatment from which the re-establishment of menstruation can be predicted, and this is the test by which in practice we must distinguish between cause and effect and mere coincidence. Change, fresh air, exercise, food, and tonics are the great therapeutic agents. Of these, change is the essential. It is easy to prescribe exercise, but not so easy to get the patient to take it while she remains in her accustomed surroundings. It is easy to order food, but dislike to food is one of the most troublesome symptoms. Tonic medicines are very good, but in this condition are the least important. Complete change, and that to surroundings in which the other indications can be complied with, is the great thing. The patient should be in a healthful place, with cheerful companions able to persuade her to exercise, and to tempt her appetite by the resources of cookery. If this can be carried out recovery will in young subjects almost always follow. But treatment of this kind is not always within the reach of the poor. For them the best change of scene and circumstances is to the hospital. The best substitute for the exercise which the patient will not take is the management of the limbs, and the muscular action provoked by the galvanic current which goes by the name of the Weir-Mitchell treatment. With this and persistent feeding appetite will return, cheerfulness come back, and when improvement has advanced menstruation will return, without special pains being taken to provoke it. The rubbing and galvanizing of the limbs, I think, are beneficial, not merely for the impression which they make on the mind of the patient, giving her an assurance that something is being done, but also because they tend to wake the patient out of gloomy meditations.—*Lancet*, Oct. 18, 1890.

Keeling on Malignant Disease of Arm Following Burn.—The patient was a woman æt. twenty-eight, whose left arm had been amputated for malignant disease commencing in the cicatrix of a burn. The scar had broken out several times and healed again, but on the last occasion (eight months previously) a large ulcer was left, which ultimately became malignant. The arm was amputated midway between the shoulder and elbow, and at first with apparently good results. A few weeks afterwards, however, the disease reappeared in the armpit, and the stump was removed at the shoulder joint, the axilla being thoroughly cleared out. The disease has since made its appearance in the surrounding skin, and would soon have a fatal issue.—*Provincial Med. Jour.*, Dec., 1890.

The Blood-Supply of Nerves.—At a recent meeting of the Academy of Sciences an interesting communication was made by MM. Quénu and Lejars on some new points in the vascular distribution in nerves. Having hit upon a novel and special method of injection, they were able to recognize in the circulatory apparatus of certain nerve trunks a series of constant dispositions hitherto little, if at all, noticed. So far their investigations have been concerned with the cervical portions of the vagus and parts of the great sympathetic. They show that the recurrent laryngeals, together with the adjacent cervical portions of the pneumogastric and sympathetic, have their blood-supply from the thyroid arteries exclusively, and the authors suggest that herein may be found a ready explanation of the aphonia as well as the respiratory and vaso-motor modifications which are observed sometimes to follow thyroidectomy and ligature of the common carotid or thyroid arteries, and they deem it not unlikely that this fact of common blood-supply may be an element in the pathology of certain forms of Graves' disease. The veins of these nerves are more abundant than the arteries, and do not always play the part of satellites to these latter, but after forming a plexus on the ganglia of the sympathetic and pneumogastric, they empty themselves into either the network of the vasa vasorum of the common and internal carotids, creating thus an intimate connection between the wall of the artery and the nerve trunks which accompany it, or they join the thyroid veins, and especially a network of veins which covers the lateral wall of the pharynx; while others open into the veins in front of the vertebræ and into those of the pre-vertebral muscles. This connection of the veins of the nerve vascular system with muscular veins was found also to exist in the case of the limbs, and the authors submit that if it be allowed that muscular contraction is a factor in the circulation in small peripheral veins, it is evident that the anatomical peculiarity observed is calculated to aid favorably the expulsion of venous blood from the nerve trunks. The writers finally suggest that the abundant blood distribution in nerves may readily conduce to congestion, and that this, in its turn, may not be without importance in the pathology—as yet but little known—of neuralgia.—*Lancet*, Nov. 3, 1890.

Savage on Some Relationships between Diabetes and Insanity.—Most diseases have a special mental aspect: thus with disorders of the digestive tract depression was common, while the mental tone of consumptives was bright and hopeful. With diabetes there was a tendency to a depressed mental tone, and beside this there were some specially interesting connections between the two disorders. The author does not claim all cases of diabetes as of neurotic origin, but he believes that some are. The facts which pointed to the central nervous origin of some cases of diabetes were overwhelming. Experiments on animals, disease and injuries in man, had shown that brain-disease did in some cases excite the disease. Writers on general medicine admitted that there were similarities between the causation of diabetes and that of nervous disorders; only very few asylum physicians had, however, recognized the relationship which he believed to exist. Dr. Clouston of Edinburgh, however, had described a class of diabetic melancholiacs; and Dr. Maudsley, in his "Pathology of Mind," had clearly pointed out that there was a very distinct connection by origin between diabetes and neuroses. Diabetes was to be regarded as a group of symptoms which, for convenience, had to be looked upon as forming a fairly definite diseased process. Among the insane he had not found sugar at all commonly in the urine. The facts upon which this paper was founded were drawn chiefly from Bethlem

Hospital. He had records of forty patients in that hospital who had diabetic relations, ten of them having diabetic parents or grandparents, fourteen having diabetic brothers or sisters, twelve aunts or uncles, and three cousins suffering from this disease. Besides these there were twelve insane patients who had both insane and diabetic relations, and ten patients who were both insane and diabetic. Nearly all the cases with diabetes and insanity were melancholic. The patients who had diabetic symptoms and then became insane almost all lost some or all of these symptoms during the period of mental disorder. There appeared to be a kind of alternation between the two disorders. He submitted cases in which acute diabetes was replaced by acute melancholia, this latter giving place again to diabetes, which once more had been replaced by temporary mental depression. In two other cases elderly men suffering from diabetes became melancholic some time before the fatal termination of the disease, and during their mental disorder no sugar appeared in the urine. In one case of general paralysis of the insane, the diabetic symptoms, which had lasted two years at least, disappeared for over a year, only to return a few months before death. In conclusion he pointed out that similar causes might give rise to either insanity or diabetes, that diabetes occurred in the same families as did insanity, and that there might be an alternation, so that insanity occurred in the one generation and diabetes in the next; again, in diabetes itself the symptoms, one or all, might be replaced for a longer or shorter time by mental symptoms.—*Lancet*, Nov. 29, 1890.

Dillingham (F. H.) on Poisoning by Sulphonal.—There has been so much said about the safety of sulphonal, and its having no effect on the heart, that I have thought it best to report a case where an elderly lady took ninety grains by mistake and alarming symptoms followed.

I had ordered for insomnia some powders, each containing thirty grains of sulphonal, with directions to take *one* in the evening.

I was called in great haste about 3 A.M., and found her in a semi-comatose condition, rapidly passing into a state of stupor, with stertorous breathing. Her radial pulse was almost imperceptible, and extremities cold.

I was told that she got out of bed to urinate a short time before, and was unable to get back, and fainted.

As soon as I had prescribed for the alarming symptoms I made an investigation, and found that she had taken *three* powders (ninety grains) at 9 P.M.

Her breathing and stupor soon improved, and her pulse became a little slower and stronger. Inco-ordination of all the muscles was extremely well marked. Her face was drawn slightly to the right side, and there was ptosis of the right eyelid. Pupils were normal.

She would doze for a few minutes and then open her eyes, but not recognize any one.

Dr. Charles W. Packard kindly saw the case with me at 6 A.M., when her general condition had slightly improved. As the doctor came into the room, she tried to ask who he was: before this, she had not seemed to appreciate the fact that any thing had happened.

Her articulation was very poor and feeble, and it was with the greatest difficulty that I could understand what she wished to say. Respirations were 24, pulse 130, and temperature 98° F. Her mouth was parched and tongue dry, and when she put it out it deviated to the right. She had a constant desire to urinate, but passed only about a teaspoonful at a time. The urine was normal.

When she attempted to raise her hands, she found it impossible to touch the place she desired.

At noon there was a slight improvement in her condition, but the inco-ordination remained about the same. She had not slept, and it was difficult to obtain an answer to any question; if you did, it was apt to be incoherent.

As her bladder was beginning to be distended, I had her urine drawn by catheter. She complained that she felt so tired, and wished that she could get a little sleep.

The next morning she was much weaker, in spite of the stimulants and milk she had taken, and her mind was not clear. Respirations were 22, pulse 130 and feeble, temperature 98½° F. Her face was not drawn quite so much to the right, and the inco-ordination and ptosis very slightly improved. Her bowels were constipated, but there was considerable tenesmus, which was finally relieved by enemata. She was not able to expel the fæces in the lower

rectum, and there was also paralysis of the sphincter muscle, as she could not retain the enema. The paralysis of the bladder still continued.

In the afternoon her mind became clear, but it was with difficulty that she could articulate; she said it tired her so much. The inco-ordination was still well marked, and it was impossible for her to use her hands for any thing. She tried to write her name, but failed.

After this her condition gradually improved, and when she was able to raise her head, complained of dizziness.

It was ten days before the ptosis, paralysis of the face, and inco-ordination of the muscles entirely disappeared. The paralysis of the bladder and bowels continued for two weeks, and then they began to gradually resume their normal functions.

This case especially differs from the others reported, in the depressing effects on the heart and the absence of sleep, also in the severity and persistence of the symptoms. It does not seem as though a drug which had proved fatal in dogs, and may cause such alarming symptoms, can be absolutely safe, even in smaller doses.—*Med. Record.*, Dec. 13, 1890.

Von Bergmann on Hæmostasis during Operation. — During operation hemorrhage is most carefully controlled by means of pieces of gauze, which have been rendered aseptic[1] shortly before. This gauze is not impregnated with any other antiseptic agent, nor is it dipped into any antiseptic solution; but is pressed perfectly dry on the bleeding surface, and then discarded. All vessels are secured with torsion-forceps or Péan's forceps, and tied with catgut ligatures. The wound must be thoroughly dry and the hemorrhage completely stopped before the sutures are applied.—*Med. Record*, Aug. 30, 1890.

Hédon on Diabetes Following Extirpation of the Pancreas.—The author has excised the pancreas of dogs in twenty-two cases, and in each case diabetic urine was passed the day following the operation and persisted until the death of the animal. Not only was sugar thus passed, but the other usual symptoms of diabetes were also developed, resulting in extreme emaciation, followed by cachexia, and, within from twenty-five to thirty days, death of the animal. In one example, however, the dog survived for a much longer period, during which time the sugar disappeared from the urine for a whole month and then reappeared. M. Hédon found, as other observers had, that if a portion of the gland, however small, was left unremoved, the diabetic symptoms did not supervene. He did not think it at all probable, as had been suggested, that the diabetes was the consequence of the cachexia which followed the destruction of the gland, for in animals in which the digestive functions of the pancreas were completely destroyed by means of paraffin injections into it diabetes did not set in.—*Lancet*, Nov. 3, 1890.

Hunger and Infection.—It is a well-known fact that hunger predisposes to certain diseases, but it has been reserved to two Turin doctors to demonstrate the increased liability experimentally. Their observations were carried out with the virus of bacillus anthrax on pigeons, a disease to which these birds are, under ordinary circumstances, refractory. They found, however, that six days' total deprivation of food rendered the birds amenable to the virus, on condition that food was still withheld. If, however, food was given at the same time as the virus then they still successfully resisted infection. Further, when starvation was continued for two days after the inoculation, and food then given, the development of the disease, though not prevented, ran a slower course. Lastly, the virus proved capable of infecting birds well fed up to the date of inoculation, but starved subsequently. The line of investigation is evidently one which admits of further research, but the moral is obvious. —*Med. Press*, Nov. 12, 1890.

[1] By prolonged exposure to dry heat.

BOOK NOTICES.

A Text-Book of Practical Therapeutics, with Special Reference to the Application of Remedial Measures to Disease and Their Employment upon a Rational Basis. By Hobart Amory Hare, M.D., B.Sc., Clinical Professor of the Diseases of Children, and Demonstrator of Therapeutics in the University of Pennsylvania, etc., etc. 8vo, pp. 632. Lea Brothers & Co., Phila., 1890.

In the preface the author says: "The treatment of 'symptoms as they arise' by the employment of remedies recommended by some eminent authority is a variety of empiricism whose existence has de-

pended largely on the fact that many physicians of the past have either been so ignorant as to be led where a writer willed, or so slothful as to be willing to let others think for them. Scientific research has so largely opened up to every one the possibility of using drugs with a distinct idea of the reason for their employment, that the writer has endeavored to bring together in a readable form the combined results of laboratory and bedside experience, thinking the time ripe for such a task."

There is a great deal about this book to commend. In the first place, as a work on Therapeutics, it is not over-burdened with contents belonging to Materia Medica or Physiology, nor is it the Practice of Medicine that some books on Therapeutics seem to be.

In the second place, an alphabetical classification of remedies is employed, the remedies being designated by their English names.

In the third place, a moderately rigid system is adhered to in enumerating physiological effects, the wonder being why the same system is not employed in stating therapeutic applications.

It is not to us apparent why Drugs, and Remedial Measures other than Drugs should be separately and differently considered; why, for instance, should cold be considered in a part of the book separate from salicylic acid or antipyrin, and why should it be considered in a more colloquial, less orderly way?

Part IV., on Diseases (their treatment), if it must be in a book on Therapeutics, is in the present work full and well done. The book closes with a table of doses of remedies, an index of drugs and remedial measures, and an index of diseases and remedies.

It is a pity that a book otherwise so "up to date" should utterly ignore the metric system.

Except in a few minor respects the book impresses the reviewer as by far the best in the English language to place in the hands of students, and amply sufficient for the average practitioner.

Hand-Book of Materia Medica, Pharmacy, and Therapeutics, including the physiological action of drugs, the special therapeutics of disease, official and extemporaneous pharmacy, and minute directions for prescription writing. By Samuel O. L. Potter, M.A., M.D., Professor of the Theory and Practice of Medicine in the Cooper Medical College of San Francisco, etc., etc. Second edition, revised and enlarged. 8vo, pp. 766. P. Blakiston, Son, & Co., Philadelphia.

The author's previous literary ventures and years of teaching have pre-eminently fitted him for the preparation of a text-book for students.

After an introduction, various definitions, and the classification of medicines, comes Part I., denominated Materia Medica and Therapeutics, in which remedies are arranged chiefly in an alphabetical way. In the case of a drug, its physical properties and chemical constituents are first briefly enumerated, then its preparations are briefly described, and all compounds into which it enters are enumerated. Description of its physiological action and therapeutic effect follow.

The second part of the book is devoted to pharmacy; the third to the treatment of diseases. An appendix with numerous tables and an index close the work.

As it stands, more space seems to be given to Materia Medica than is necessary. In the enumeration of physiological effects and therapeutic actions, no rigid form of classification or order seems to be followed—a really fatal defect in a book designed for students' use, as a close adherence to some sort of system is absolutely essential to easy memorizing. As to quality and amount, the material under materia medica and therapeutics could not well be improved upon.

Part II., on Pharmacy and Prescription Writing, occupies seventy-one pages, and is very ample for a work of the present scope.

Part III., on Special Therapeutics, occupies 211 pages. While we have generally considered objectionable the common custom of an index of diseases and the remedies therefor in a short space at the back of a book, we cannot entirely condemn the same idea so elaborately worked out as in the present book—particularly as it makes pathological conditions, as far as possible, and not diseases or symptoms, indications for treatment.

The appendix, thirty-six pages, contains many things which seem out of place in a book on therapeutics, among which may be enumerated: several pages on differential diagnosis, notes on temperature in disease, obstetrical memoranda, clinical examination of the urine, and some notes on ethics.

The Physician's Visiting List for 1891; Fortieth Year.—P. Blakiston, Son, & Co., Philadelphia.

This visiting list is published in four editions: regular, interleaved, perpetual, and monthly, to suit the tastes and requirements of its various patrons. It contains much material of great value to the physician for ready reference, besides being a business record of great simplicity and compactness.

The Patient's Record for the Use of Physicians and Nurses.—Compiled by Agnes S. Brennan. G. P. Putnam's Son, New York and London, 1890.

A blank 8vo volume of 99 pages, the first part of which is ruled for bedside-notes as follows: Separate columns for date, time, temperature, pulse, respiration, medicine, nourishment, stimulants, remarks, and urine. Interleaved between these pages are detachable slips for the doctor's orders. At the back of the book are twelve detachable temperature, respiration, pulse, and urine charts, conveniently ruled in red and blue.

The Physician's All-Requisite Time- and Labor-Saving Account-Book.—Designed by William A. Seibert, M.D. F. A. Davis, Philadelphia and London.

An indexed book, 10 x 12 inches, furnishing physicians a quick, accurate, and comprehensive method of keeping their accounts. No. 1 has 300 pages for 900 accounts per year; No. 2 has 600 pages for 1,800 accounts per year. Price $5 and $8. It has no cipher-code, has one entry, requires no posting, transferring of accounts, or balancing.

The Medical Bulletin Visiting List, or Physician's Call Record.—F. A. Davis, Philadelphia and London.

A visiting list with special memoranda arranged upon an original and convenient monthly and weekly plan for the daily recording of professional visits.

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3 gal
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3 gal
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